RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION

CHAPTER 1200-13-12
BUREAU OF TENNCARE

TABLE OF CONTENTS

1200-13-12-.01 DEFINITIONS

BENEFITS shall mean a schedule of health care services to be delivered to enrollees covered in the managed care organization's plan.

BEHAVIORAL HEALTH ORGANIZATIONS shall mean a type of managed care organization approved by the Tennessee Department of Finance and Administration to deliver mental health and substance abuse services to TennCare enrollees. The Department of Finance and Administration may delegate this task to a designee, which may be the Tennessee Department of Mental Health and Mental Retardation.

BUREAU OF TENNCARE shall mean the division within the Tennessee Department of Finance and Administration responsible for administering the TennCare program.

CAPITATION PAYMENT shall mean the fee which is paid by the state to a managed care organization for each enrollee covered under a plan for the provision of medical services, whether or not the enrollee utilizes services or without regard to the amount of services utilized during the payment period.

CPT4 CODES are descriptive terms contained in the Physician's Current Procedural Terminology, used to identify medical services and procedures performed by physicians or other licensed health care professionals.

CAPITATION RATE shall mean the amount established by the state for the purpose of providing payment to enrolled managed care organizations.

CHRONICALLY MENTALLY Ill persons shall mean individuals who have been identified by the Tennessee Department of Mental Health and Mental Retardation as having significant psychiatric disorders requiring that they receive psychiatric treatment, comprehensive community support, and ancillary assistance.

COBRA shall mean health insurance coverage provided pursuant to the Consolidated Omnibus Budget Reconciliation Act.

COMMUNITY SERVICE AREA shall mean one (1) or more counties in a defined geographical area in which the managed care organization is authorized to enroll and serve TennCare enrollees residing in that community service area in exchange for a monthly capitation payment. Community Service Areas shall correspond to Community Health Agency Regions.

COST SHARING shall mean the amounts that certain enrollees are required to pay for their TennCare services. "Cost sharing" includes premiums, deductibles and coinsurance or copayments.

(Rule 1200-13-12-.01, continued)

DISENROLLMENT shall mean the discontinuance of an individual's entitlement to receive covered services. The Bureau of TennCare must approve all disenrollments. TennCare will notify the enrollee of the reason for disenrollment and the right to an appeal under the procedures set out in rule 1200-13-12-.12.

EMERGENCY MEDICAL CONDITION means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in:

(a) Placing the person's (or with respect to a pregnant woman, her unborn child's) health in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

EMPLOYER-SPONSORED HEALTH INSURANCE PLAN shall mean health insurance that is available to an individual, and/or to the individual's family, as the result of that individual's employment. The employer does not have to pay all or a part of the premium for a health insurance plan to be considered employer-sponsored.

ENROLLEE shall mean any TennCare eligible person who has enrolled in a managed care organization authorized to provide services in the geographical area where the enrollee resides.

ENROLLMENT shall mean the process by which a TennCare eligible person becomes a member of a managed care organization.

ENROLLMENT CAP shall mean the maximum number of individuals who can be enrolled in TennCare at a given time.

FAMILY FOR NON-MEDICAID TENNCARE PURPOSES is defined as one of the following:

(a) 1. A married couple residing at the same address without children in the home; or

2. A married couple and their children or step-children under age nineteen (19) residing at the same address; or

3. A single parent and children under age nineteen (19) residing at the same address; or

4. A guardian with children under age nineteen (19) residing at the same address; or

5. An unmarried adult under age nineteen (19) with no children; or

6. An unmarried minor female who has one or more children, and/or is pregnant. If the mother is TennCare eligible, the baby will be added upon notification in writing of the child's birth; or

7. An emancipated minor as defined at T.C.A. 39-11-106(a)(10); or

8. A non-parental caretaker, relative, guardian, etc., who has legal proof of responsibility, guardianship or custodial care for a minor child, as evidenced by, but not limited to, adoption papers, court-ordered guardianship, or other court-ordered assignment making an adult responsible for the care and support of a minor.

(b) All members of a family unit must be listed on a TennCare application regardless of whether each person wants TennCare or is eligible for TennCare under current eligibility criteria at the time of application. Social Security number and citizenship status are not required unless an individual is applying for TennCare.

(c) An individual marrying into a TennCare household, children from a previous marriage moving into a TennCare household, or children moving in with a TennCare covered guardian are not automatically given TennCare coverage. While inclusion of these individuals can impact cost sharing responsibilities, they must meet current TennCare eligibility criteria to be given coverage.

(d) Excluded from this definition are two or more unmarried adults residing at the same address.

FRAUD shall mean an intentional deception or misrepresentation made by a person who knows or should have known that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

HEALTH CARE FINANCING ADMINISTRATION (HCFA) shall mean the agency within the United States Department of Health and Human Services that is responsible for administering Title XVIII, Title XIX and Title XXI of the Social Security Act.

HEALTH INSURANCE, for purposes of these regulations, means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contracts. "Health insurance" does not include short term, accident, fixed indemnity, long-term care insurance, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

HEALTH PLAN shall mean a prepaid health care package developed and operated by a managed care organization. For the purposes of these rules, the term "health plan" shall not refer to plans offered by the behavioral health organizations.

HEALTH MAINTENANCE ORGANIZATION (HMO) shall mean an entity licensed by the Tennessee Department of Commerce and Insurance under applicable provisions of *Tennessee Code Annotated (T.C.A.)* Title 56, Chapter 32.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

INCOME shall mean the adjusted gross income as shown on the applicant's/enrollee's most recent, complete income tax return plus any Social Security payments, Veteran's Administration benefits, Railroad Retirement benefits, or any other retirement or disability plans received that is not included in the adjusted gross income. Income does not include child support payments. Income does not include money earned by a dependent child under the age of nineteen (19).

(a) Proof of income may be shown by:

1. An applicant's/enrollee's last complete income tax return; or

2. An applicant's/enrollee's most recent IRS quarterly estimate of taxes; or

3. A signed letter or statement from the applicant's/enrollee's employer stating the individual's income; or

4. Check stubs from employer or source of assistance; or

5. The equivalent proof of direct deposit of funds (ex: an institutional statement showing deposited funds and their source); or

6. A copy of an entitlement letter to benefits from, but not limited to, Social Security, Veteran's Administration, Railroad Retirement, or any other retirement or disability plan.

(b) All non-Medicaid eligibles must comply with the following:

1. Report the income, as defined above, for the family members listed on the application for use in determining cost sharing responsibilities. There is no resource limit for TennCare eligibility for non-Medicaid eligible individuals.

2. Changes in family income and/or household composition, such as the addition of a family member or the deletion of someone no longer in the household, must be reported in writing to the Bureau of TennCare - Member Services within sixty (60) days of the change. Any changes in cost sharing responsibilities as the result of a change in income or family size will become effective the first day of the month following the month of notification to TennCare.

INMATE shall be defined as an individual confined for a criminal offense in a local, state, or federal prison, jail, youth development center, or other penal or correctional facility, including a furlough from such facility.

LONG TERM CARE shall mean institutional services of a nursing facility, an intermediate care facility for the mentally retarded and services provided through a Home and Community Based Services Waiver.

MANAGED CARE ORGANIZATION shall mean an appropriately licensed Health Maintenance Organization or a Preferred Provider Organization approved by the Bureau of TennCare as capable of providing medical services in the TennCare program.

MEDICALLY NECESSARY shall mean services or supplies provided by an institution, physician, or other provider that are required to identify or treat a TennCare enrollee's illness or injury and which are:

(a) Consistent with the symptoms or diagnosis and treatment of the enrollee's condition, disease, ailment or injury; and

(b) Appropriate with regard to standards of good medical practice; and

(c) Not solely for the convenience of an enrollee, physician, institution or other provider; and

(d) The most appropriate supply or level of services which can safely be provided to the enrollee. When applied to the care of an inpatient, it further means that services for the enrollee's medical symptoms or condition require that the services cannot be safely provided to the enrollee as an outpatient; and

(e) When applied to enrollees under 21 years of age, services shall be provided in accordance with EPSDT requirements including federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989.

MEDICARE shall mean the program administered through the Social Security Administration pursuant to Title XVIII, available to most individuals upon attaining age 65, to some disabled individuals under 65 years of age, and individuals having End Stage Renal Disease (ESRD).

MENTAL HEALTH PLAN shall mean a prepaid mental health and substance abuse care package developed by and/or operated by a behavioral health organization.

PREFERRED PROVIDER ORGANIZATION shall mean a managed care organization other than an HMO which is approved by the Bureau of TennCare as capable of providing medical services in the TennCare program.

PROVIDER shall mean an institution, facility, agency, person, corporation, partnership, or association which accepts, as payment in full for providing benefits to a TennCare enrollee, the amounts paid pursuant to an approved agreement with a managed care organization. Such payment may include fees, deductibles, copayments, special fees or any combination of these.

REASSIGNMENT shall mean that process by which the Bureau of TennCare transfers an enrollee from one managed care organization (MCO) to another as described at rule 1200-13-12-.03(4).

RESOURCES FOR MEDICAID ELIGIBLE INDIVIDUALS shall be defined in Chapter 1240-3-3 of the Rules of the Tennessee Department of Human Services, Division of Medical Services.

SERIOUSLY EMOTIONALLY DISTURBED (SED) shall mean persons who have been identified by the Tennessee Department of Mental Health and Mental Retardation or its designee as meeting the criteria provided below. For purposes of these rules, this definition shall not include children in the legal custody of the Tennessee Department of Children's Services.

(a) Age from birth to age 18, and

(b) Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV (and subsequent revisions) "V" codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable serious emotional disturbance. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects; and

(c) The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and is evidenced by a Global Assessment of Functioning score of 50 or less in accordance with the DSM-IV (and subsequent revisions). Children and adolescents who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

SEVERELY AND/OR PERSISTENTLY MENTALLY ILL (SPMI) shall mean individuals who have been identified by the Tennessee Department of Mental Health and Mental Retardation ("TDMHMR") or its designee as meeting the criteria provided in (30)(a). These persons will be identified as belonging in one of the Clinically Related Groups listed in (30)(b).

(a) Criteria

1. Age 18 and over; and

2. Currently, or at any time during the past year, has had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV (and subsequent revisions) of the American Psychiatric Association, with the exception of DSM-IV (and subsequent revisions) "V" codes, substance use disorders, and developmental disorders, unless these disorders co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features, however, they vary in terms of severity and disabling effects; and

3. The diagnosable mental, behavioral, or emotional disorder identified above has resulted in functional impairment which substantially interferes with or limits major life activities. Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in major life activities including basic living skills (e.g., eating, bathing, dressing); instrumental living skills (maintaining a household, managing money, getting around in the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. This definition includes adults who would have met functional

impairment criteria during the referenced year without the benefit of treatment or other support services.

(b) Definitions of Clinically Related Groups

1. Clinically Related Group 1. Any person 18 years or older whose functioning is, or in the last six months has been, severely impaired and the duration of the impairment totals six months or longer in the past year. This person requires constant assistance or supervision with daily living activities and displays an inability to relate to others which interferes with his/her ability to work and his/her family relationships and usually results in social isolation in the community. Changes in the environment are stressful and may result in further withdrawal or dysfunction in other areas. Support is needed to insure the person's safety and survival.

2. Clinically Related Group 2. Any person 18 years of age or older whose functioning is, or in the last six months has been, severely impaired and the duration of the impairment totals less than six months in the past year. This individual has extensive problems with performing daily routine activities and requires frequent assistance. He/she has substantial impairment in his/her ability to take part in social activities or relationships which often results in social isolation in the community. The person has extensive difficulty in adjusting to change. Assistance with activities of daily living is necessary to survival in the community. This person has difficulty completing simple tasks but with assistance could work in a highly supervised setting.

3. Clinically Related Group 3. Any person 18 years of age or older whose functioning has not been severely impaired recently (within the last six months), but has been severely impaired in the past to the extent that he or she needs services to prevent relapse. This individual generally needs long term continued support. Characteristics of this population may include regular or frequent problems with performing daily routine activities. He/she may require some supervision although he/she can survive without it. This person has noticeable disruption in social relations, although he or she is capable of taking part in a variety of social activities. Inadequate social skills have a serious negative impact on the person's life; however, some social roles are maintained with support. This person can complete tasks without prompting and help and can function in the workplace with assistance even though the experience may be stressful. There is sometimes noticeable difficulty in accepting and adjusting to change, and the person may require some intervention.

TENNCARE shall mean the program administered by the Department of Finance and Administration pursuant to a Title XIX waiver granted to the State of Tennessee.

A DISLOCATED WORKER shall mean a person who previously had health insurance through their employer and who becomes uninsured due to bona fide closure of the employer's business or plant. A business or plant will not be considered closed if it declares bankruptcy or otherwise declares it is going out of business when the purpose, primary or otherwise, of such declaration is to establish TennCare coverage for its employees and the business or plant intends to reopen under the same or another identity with essentially the same ownership and/or management.

THIRD PARTY shall mean any entity or funding source other than the enrollee or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care of the enrollee.

UNINSURABLE shall mean any person who is unable, because of a prior existing or existing medical condition, to purchase health insurance.

UNINSURED shall mean any person who does not have health insurance under an individual health insurance policy or who does not have, directly or indirectly through another family member, coverage under or access to employer-sponsored health insurance, or COBRA benefits throughout the COBRA benefits period, or another government health plan, and continues to lack this access. "Another government health plan" shall include, but not be limited to, benefits from Medicare or TRICARE (formerly CHAMPUS). "Another government health plan" shall

(Rule 1200-13-12-.01, continued)

not include Veteran's Administration benefits, nor health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Care Act.

TENNCARE PARTNERS PROGRAM shall mean the component of the TennCare Program that provides mental health and substance abuse services.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT (EPSDT) means:

(a) Screening in accordance with professional standards, interperiodic screening and diagnostic services to determine the existence of physical or mental illness or conditions in recipients under age 21; and

(b) Health care, treatment, and other measures, described in 42 USC §1396a(a) to correct or ameliorate any defects and physical and mental illnesses and conditions discovered.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, Executive Order No. 11 of 1997, and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed November 30, 1994; effective February 3, 1995. Amendment filed May 5, 1997; effective July 19, 1997. Amendment filed October 31, 1997; effective January 12, 1998. Amendment filed July 14, 1998; effective September 27, 1998. Amendment filed October 20, 1999; effective January 3, 2000. Amendment filed February 10, 2000; effective April 25, 2000. Amendment filed June 22, 2000; effective September 5, 2000. Amendment filed October 23, 2000; effective January 6, 2001. Amendment filed July 6, 2001; effective September 19, 2001.*

1200-13-12-.02 ELIGIBILITY

(1) DELINEATION OF AGENCY ROLES AND RESPONSIBILITY

(a) The Tennessee Department of Finance and Administration is the lead State agency for TennCare and is responsible for establishing policy and procedural requirements and criteria.

(b) The Tennessee Department of Human Services (TDHS) is under contract with the Department of Health to determine Medicaid eligibility. Eligibility for individuals who are uninsured or uninsurable will be determined by the Bureau of TennCare.

(c) The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) program. In Tennessee, SSI recipients are automatically eligible for Medicaid. All SSI recipients are therefore TennCare eligibles.

(d) Other Agencies and local health departments will be responsible for providing application forms to persons potentially eligible for TennCare and for helping these persons in completing applications when necessary. TennCare eligibles who might meet eligibility criteria for Medicaid as the program was administered during state fiscal year 1992-93 will be referred to TDHS. In addition, these agencies will be responsible for providing information about the TennCare program. For purpose of enrolling children under age eighteen (18) as described at rule 1200-13-12-.03(1)(b)4., children under age nineteen (19) as described at rules 1200-13-12-.03(1)(b)6. and 1200-13-12-.03(1)(c) and dislocated workers and their families as described at rule 1200-13-12-.03(1)(b)5., local health departments will be responsible for verifying information on the enrollment application, confirming eligibility, and collecting applicable premiums, if any.

(e) The Commissioner may delegate the management functions associated with the TennCare Partners Program, the TennCare Program component for delivery of mental health and substance abuse services, to TDMHMR.

(2) TECHNICAL ELIGIBILITY REQUIREMENTS FOR TENNCARE

(a) All Medicaid eligible individuals must:

1. Meet all technical requirements applicable to the appropriate category of medical assistance as described in Chapter 1240-3-3 of the Rules of the Tennessee Department of Human Services - Division of Medical Services; or

2. Be approved for the Supplemental Security Income (SSI) program by the Social Security Administration.

(b) All non-Medicaid-eligible individuals must meet the following technical requirements:

1. Must be able to document status as either a U.S. citizen, a non-citizen national, or as an alien in eligible immigration status. Acceptable documentation includes, but is not limited to, the following:

(i) A certified birth certificate;

(ii) Naturalization papers;

(iii) Notarized affidavit of birth;

(iv) A resident alien green card;

2. Must be a Tennessee resident;

3. Must present a Social Security number or proof of having applied for one. Acceptable documentation includes, but is not limited to, the following:

(i) A Social Security Card or a copy of one;

(ii) A Tennessee Driver's License, or copy, that has the individual's Social Security number;

(iii) A federal income tax return showing Social Security numbers;

(iv) Documentation from the Social Security Administration showing the individual's Social Security number, or a receipt where a number has been applied for; or

(v) Federal, state, or local government correspondence showing the individual's name and Social Security number;

4. Must not be an inmate as defined at rule 1200-13-12-.01;

5. Must not be eligible for participation in Medicare, except those individuals who are determined to be uninsurable or dually eligible for Medicare and Medicaid;

6. Must not be eligible for participation in TRICARE (formerly known as CHAMPUS), except those individuals who are also determined to be eligible for Medicaid;

7. Must not be enrolled in an individually funded, non-employer sponsored health insurance plan, except for a limited benefits policy;

8. Must not be eligible for participation in an employer sponsored health insurance plan, either directly or indirectly through another family member, except that uninsured

children under age nineteen (19) whose family income is below 200% of the federal poverty level shall be eligible for TennCare even if they have access to employer sponsored health insurance through a parent;

9. Must respond to all requests for reverification of eligibility from the Bureau of TennCare, as described at rule 1200-13-12-.02(9); and

10. Must not be responsible for past due TennCare premiumobligation(s).

(c) The Bureau of TennCare will also have access to third party resource information on current Medicaid eligibles. Managed Care Organizations will release insurance information from their files to the Bureau of TennCare on a regular basis, as required in the contract between the Managed Care Organizations and the Tennessee Department of Finance and Administration or the Tennessee Department of Mental Health and Developmental Disabilities, as applicable.

(3) FINANCIAL ELIGIBILITY REQUIREMENTS FOR TENNCARE

(a) All Medicaid eligible individuals must:

1. Meet all financial eligibility requirements applicable to the appropriate category of medical assistance as described in Chapter 1240-3-3 of the Rules of the Tennessee Department of Human Services - Division of Medical Services; or

2. Meet the financial requirements for the Supplemental Security Income (SSI) program of the Social Security Administration.

(b) All Non-Medicaid TennCare Eligibles must comply with the following:

1. Report the income, as defined at rule 1200-13-12-.01, of the family members listed on the application for use in determining cost sharing responsibilities. There is no resource limit for TennCare eligibility for non-Medicaid eligible individuals.

2. Changes in family income and/or household composition, such as the addition of a new family member or the deletion of someone no longer in the household, must be reported in writing to the Bureau of TennCare - Member Services within sixty (60) days of the change. Any changes in cost sharing responsibilities as the result of a change in income or family size will become effective the first day of the month following the month of notification to TennCare.

(4) COVERAGE GROUPS UNDER TENNCARE

(a) Eligibility for TennCare is limited to individuals who meet one of the following criteria:

1. Would have been Medicaid eligible under the Medicaid program as it was administered during the fiscal year 1992-93;

2. Are uninsurable as defined at rule 1200-13-12-.01;

3. Are uninsured as defined at rule 1200-13-12-.01. Such person(s) must report changes in employment status to the Bureau in writing within sixty (60) days so that the Bureau can determine access to (or lack of) employer sponsored health insurance;

4. Dislocated workers and their families as defined at rule 1200-13-12-.01. Such workers and their families shall be eligible for TennCare coverage without regard to the availability of COBRA benefits. Enrollment in TennCare for such workers and their

families shall be subject to the availability of federal funding. TennCare family coverage is available to the families of workers eligible under this section only if the worker had employer sponsored health insurance family coverage at the time of the employer's business closing or layoff.

(i) Enrollment will become effective upon confirmation of eligibility criteria and payment of any applicable premiums. A worker eligible under this section shall have the option to prepay the first month's premium, if any, and select a later effective date. The TennCare cost sharing items will be based on family income.

(ii) Enrollment in TennCare will continue until employer sponsored health insurance is available to the dislocated worker or his/her spouse. Changes in employment status shall be reported to TennCare in writing within sixty (60) days in order to facilitate the determination of employer sponsored health insurance.

(iii) TennCare coverage will not be available under this section to workers or their families if employer sponsored health insurance is available through the dislocated worker's spouse.

5. Children under age nineteen (19) who meet the TennCare uninsured criteria as set forth at paragraph (2) of this rule.

6. Uninsured children under age nineteen (19) whose family income is less than 200% of poverty are eligible for TennCare coverage, even though the family may have access to health insurance but due to the family financial situation cannot afford it. When the family's income equals or exceeds 200% of poverty and the family has access to health insurance, TennCare eligibility for children under age nineteen (19) who are eligible under this section will end.

(b) The phrase "the Medicaid program as it was administered in state fiscal year 1992-93" refers to Medicaid policies and regulations regarding coverage groups and methodologies. Specific income and resource standards (e.g. 100% of poverty) and age groups will be updated each year of TennCare.

(c) TennCare reserves the right to implement changes in eligibility laws, policies, and regulations occurring after state fiscal year 1992-93 if these changes are appropriate for the TennCare population.

(5) LOSS OF ELIGIBILITY

(a) Medicaid eligibility for TennCare shall cease when the individual no longer qualifies for Medicaid as administered in state fiscal year 1992-93, subject to updating of income, age, and resource standards as specified in Chapter 1240-3-3 of the Rules of the Tennessee Department of Human Services, Division of Medical Services. Persons losing Medicaid eligibility for TennCare who have no access to insurance may remain in TennCare if they are determined to meet the non-Medicaid TennCare eligibility criteria. At such time as these persons are determined to meet non-Medicaid eligibility criteria for TennCare, they will be subject to enrollee cost-sharing as defined in 1200-13-12-.05.

(b) Non-Medicaid eligibility for TennCare shall cease when one or more of the following situations exist:

1. The enrollee becomes eligible for participation in an employer sponsored health insurance plan, either directly or indirectly through a family member;

(Rule 1200-13-12-.02, continued)

2. The enrollee becomes eligible for participation in Medicare or in TRICARE (formerly CHAMPUS) unless the enrollee is also eligible for Medicaid or is Medicare eligible and uninsurable;

3. The enrollee purchases or becomes covered by an individually funded, non-employer sponsored health insurance plan, other than a limited benefits policy, as defined by these rules;

4. It is determined that the enrollee falsified the application for TennCare and approval was based upon this false information;

5. The enrollee fails to pay the required premiums in order to enroll and/or remain enrolled in the TennCare system. There will be a grace period of up to sixty (60) days allowed by TennCare prior to disenrollment proceedings;

6. The enrollee has been determined able but simply unwilling to pay the applicable deductibles, copayments and/or special fees for services received and the Bureau of TennCare has authorized disenrollment;

7. It is determined that an enrollee has abused the TennCare system by allowing an ineligible person to utilize the enrollee's TennCare identification card to obtain services, subject to state and federal laws and regulations;

8. The individual fails to comply with TennCare's requirements, subject to state and federal laws and regulations;

9. It is determined that the enrollee has abused the TennCare program by using the TennCare identification card to seek or obtain drugs or supplies illegally or for resale, subject to state and federal laws and regulations;

10. Death of enrollee;

11. It is determined that any of the technical eligibility requirements of rule 1200-13-12-.02(2)(b) are no longer met and the Bureau of TennCare has authorized disenrollment;

12. The enrollee has failed to respond to a reverification process requirement, as described at rule 1200-13-12-.02(9), to assure that the enrollee, and other family members as appropriate, remains eligible for TennCare;

13. When the Bureau of TennCare - Member Services receives a voluntary written request for termination of eligibility from a non-Medicaid TennCare enrollee;

14. When an enrollee no longer qualifies as a resident of Tennessee under state and federal law;

15. When an individual becomes incarcerated as an inmate; or

16. When the enrollee is no longer eligible for TennCare.

(6) and (7) RESERVED.

(8) TENNCARE PARTNERS PROGRAM

(a) Persons who are enrolled in the TennCare Program are automatically enrolled in the TennCare Partners Program, which is the component of the TennCare Program that delivers mental health

and substance abuse services. Persons who are disenrolled from the TennCare Program are also automatically disenrolled from the TennCare Partners Program, except in the situation described in Section (8)(b).

(b) Certain persons who have lost or been denied TennCare eligibility may be eligible for the TennCare Partners Program without being eligible for TennCare. These persons must meet the following criteria:

1. They have been identified by the Tennessee Department of Mental Health and Mental Retardation or its designee as Seriously and/or Persistently Mentally Ill or Seriously Emotionally Disturbed;

2. Their family incomes do not exceed 100% of the federal poverty level, consistent with the figures provided in 1200-13-12-.05;

3. They have been determined ineligible for TennCare; and

4. They do not have health insurance.

(c) TennCare enrollees who lose TennCare eligibility will automatically lose eligibility for the TennCare Partners Program, except if they meet the criteria outlined in (8)(b). Persons who meet these criteria may participate in the TennCare Partners Program even though they do not participate in the TennCare Program. These non-TennCare eligible persons will be disenrolled from the TennCare Partners Program under the following circumstances:

1. When the individual no longer meets the criteria outlined in (8)(b) or is found to have falsified information provided to the Tennessee Department of Mental Health and Mental Retardation and approval was based on this false information;

2. When the individual who voluntarily enrolled in the TennCare Partners Program voluntarily requests disenrollment;

3. When the individual moves out of State;

4. When the individual abused the TennCare Partners Program (for example, by using or allowing an ineligible person to use the individual's identification card to seek or obtain drugs or supplies illegally or for resale, subject to State and federal laws and regulations); or

5. Death of the individual.

(9) REVERIFICATION OF ELIGIBILITY

All TennCare enrollees shall periodically prove that they remain eligible for participation in the TennCare program. The eligibility process through which they enrolled in TennCare determines how this reverification is done.

(a) Enrollees in TennCare who qualified as Medicaid eligible shall reverify their Medicaid eligibility as required by the appropriate category of medical assistance as described in Chapter 1240-3-3 of the Rules of the Tennessee Department of Human Services - Division of Medical Services; those enrollees eligible through the Supplemental Security Income (SSI) program of the Social Security Administration (SSA) shall follow the reverification process as required by the SSA.

(Rule 1200-13-12-.02, continued)

(b) A non-Medicaid TennCare enrollee must reverify eligibility as requested by the Bureau of TennCare. The enrollee's eligibility to remain on TennCare is determined as of the date of the reverification interview.

1. The reverification process requires that the enrollee, or responsible party, arrange for a reverification interview at the health department of the county in which he/she resides. The notice of reverification will be sent to the latest address of record that the Bureau of TennCare has on file for that individual. Reasonable accommodations will be made for persons with disabilities who require assistance in responding to a reverification request.

2. Information to be reverified includes changes in address, income, employment, family size, access to health insurance, and verification of Social Security numbers. Reverification interviews must be scheduled and kept regardless of whether any changes have occurred. It is the responsibility of the enrollee to furnish all information requested. The notice notifying the enrollee that a reverification of eligibility is needed will inform the enrollee of what documentation is to be brought to the review.

3. If as a result of the review it is found that any enrollee no longer meets the technical eligibility requirements as set out at rule 1200-13-12-.02(2), those enrollee(s) will be disenrolled from TennCare. The enrollee will be sent a notice of termination, and such enrollee has the right to appeal such decision within thirty-two (32) calendar days of the date of the letter informing the enrollee of loss of eligibility. The enrollee's right to appeal is set out at rule 1200-13-12-.12.

4. Reverification of eligibility may occur annually, or at any time the Bureau determines a review is needed.

(c) The reverification process for non-Medicaid enrollees consists of the following:

1. A notice is mailed to the enrollee's most current address in the Bureau's files. This notice informs the enrollee that a review of eligibility for TennCare is needed, and how to arrange for the review.

2. A second notice will be mailed due to non-response (the enrollee's failure to schedule a review) or as a result of returned mail. The second notice will be mailed ninety (90) days following the date of the initial notice, informing the enrollee that failure to respond will result in termination of eligibility in thirty-two (32) days. The Bureau will make reasonable attempts to locate an enrollee whose mail was returned to the Bureau. Such measures include, but are not limited to, mailing another notice requesting that the U.S.P.S. forward the mail if possible; contacting the enrollee's MCO requesting assistance in locating the enrollee; or other measures as appropriate. Return of the second notice as undeliverable will result in the termination of TennCare eligibility at the end of the thirty-two (32) day period as stated in the second notice. However, if such an individual contacts TennCare and successfully completes the reverification process within sixty (60) calendar days following termination of TennCare eligibility, this individual will be reinstated with no lapse in eligibility.

3. Once an eligibility review is scheduled, the enrollee must keep the appointment. If necessary, a review may be re-scheduled a maximum of two (2) times for a period not to exceed sixty (60) calendar days from the date of the notification notice. Failure to complete the reverification process within sixty days (60) days of the date of the notification notice will result in termination of TennCare eligibility as stated at rule 1200-13-12-.02(5)(b)12. If the last day of the 60-day period for scheduling and keeping a reverification interview falls on a weekend or State holiday, the enrollee has until the next State business day to have the interview.

4. It is the responsibility of the enrollee or responsible party to furnish all information required to determine if the enrollee, and other family members as appropriate, remains eligible for TennCare. If during the review of eligibility it is found that the enrollee lacks necessary information, the review process may be put on hold for a period not to exceed thirty (30) calendar days from the date of the interview. If the enrollee fails to provide the information by the expiration of the thirty (30) day extension the enrollee's TennCare eligibility will be terminated. If the last day of the extension falls on a weekend or State holiday, the enrollee has until the next State business day to provide the missing information. This thirty (30) day extension is the only exception that will permit the review period to continue more than the sixty (60) day period as described in Part 3. above. Under no circumstances shall the total reverification period exceed one hundred and twenty (120) days from the date of the initial notification letter.

Authority: *T.C.A §§4-5-202, 71-5-105, 71-5-109, 71-5-113, Executive Order No. 11 of 1997, and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed November 30, 1994; effective February 3, 1995. Amendment filed May 5, 1997; effective July 19, 1997. Amendment filed October 31, 1997; effective January 12, 1998. Amendment filed April 20, 1998; effective July 4, 1998. Amendment filed July 28, 1998; effective October 11, 1998. Amendment filed February 10, 2000; effective April 25, 2000. Amendment filed July 6, 2001; effective September 19, 2001.*

1200-13-12-.03 ENROLLMENT, DISENROLLMENT, RE-ENROLLMENT, AND REASSIGNMENT.

(1) ENROLLMENT

Persons determined eligible to enroll in TennCare by the Tennessee Department of Human Services or the Tennessee Department of Health shall do so in accordance with the following:

(a) Total enrollment in TennCare shall not exceed 1,300,000 in the first full year of operation and shall not exceed 1,500,000 thereafter.

(b) The following TennCare eligibles shall be allowed to enroll in TennCare at any time:

1. Persons who would have been eligible for Medicaid in state fiscal year 1992-93;

2. Persons who are unable, because of an existing medical condition, to purchase health insurance but who meet the guidelines for the Tennessee Comprehensive Health Insurance Program; and

3. Persons who have lost access to COBRA coverage and who otherwise meet the definition of uninsured.

4. Children under the age of eighteen (18) who do not have health insurance and do not have current access to health insurance on date of application through any employer or government sponsored health plan (either directly or through a family member). Children under the age of eighteen (18) whose parent(s) or guardian(s) have COBRA coverage availability will be allowed to enroll.

5. Dislocated workers as set out at rule 1200-13-12-.01(33) and family of dislocated workers. Such workers and their family shall be eligible for TennCare coverage without regard to the availability of COBRA insurance. Enrollment in TennCare shall be subject to the availability of federal funding.

(i) Enrollment will become effective upon confirmation of eligibility criteria and payment of any applicable premiums. The dislocated worker shall have the option

to prepay the first month's premium, if any, and select a later effective date. TennCare premiums will be based on family income as it is for any other uninsured or uninsurable applicant.

(ii) Enrollment in TennCare will continue until employer sponsored health insurance is available to the dislocated worker or his/her spouse.

(iii) Dislocated workers will be required to report changes of employment in order to facilitate the determination of availability of employer sponsored health insurance.

(iv) TennCare coverage will not be available to dislocated worker or their family if employer sponsored health insurance is available through the dislocated worker's spouse

6. Effective January 1, 1998 uninsured children under age nineteen (19) who meet the TennCare uninsured criteria as set out at rule 1200-13-12-.01(36). Enrollment in TennCare shall be subject to the availability of federal funding.

(c) Effective January 1, 1998 enrollment shall be granted to uninsured children under age nineteen (19) with family incomes below two hundred percent (200%) of poverty who have access to health insurance but because of their family financial situation cannot afford it. Open enrollment for these children will be held from January 1, 1998 through December 31, 1998. On December 31, 1998, enrollment for these children will be closed. In the future, TennCare will open enrollment for these children as it deems necessary. TennCare will keep enrollment open through December 31, 1998, consistent with the enrollment opportunities for children who do not have access to health insurance subject to the following conditions:

1. HCFA approval of the TennCare expansion request; and

2. HCFA not placing constraints on children with access to insurance which differ from those placed on children without access to insurance.

Enrollment in TennCare shall be subject to the availability of federal funding.

(d) Enrollees will have a forty-five day (45) period after initially selecting or being assigned to a health plan to change health plans. No additional changes will be allowed except as otherwise specified in these rules.

(e) Persons who are eligible for TennCare as uninsurables shall be enrolled in the TennCare program effective on the date on which TennCare or its authorized representative has received both a completed application and proof of uninsurability.

(f) In order for an individual to be eligible for TennCare as an uninsurable, the applicant must comply with the following criteria, as applicable:

1. In order for an individual without health insurance to be eligible for TennCare as an uninsurable, the applicant must demonstrate acceptable proof of uninsurability. Proof of uninsurability is a letter of denial of health insurance coverage which is based on the applicant's health status and which has been issued by an insurance company or its authorized agent within the twelve (12) month period preceding the TennCare application.

2. In order for an individual with a health insurance policy other than Medicare to be eligible for TennCare as a "limited benefits" uninsurable, the applicant must submit one

of the following forms of documentation from an insurance company or its authorized agent:

(i) The applicant must submit documentation that the health insurance policy has a specific exclusion or rider of non-coverage based on a specific prior existing or existing condition (e.g., diabetes), category of medical conditions (e.g., mental illness), or treatment of such specific prior existing or existing condition or category of medical condition. For purposes of this rule, a prior existing or existing condition exclusion for any condition reasonably anticipated to last less than twelve (12) months if untreated does not qualify an applicant for TennCare as a "limited benefits" uninsurable, unless the applicant is considered to be terminally ill due to a condition which has a medical prognosis that the applicant's life expectancy is six (6) months or less; or

(ii) The applicant must submit documentation that the insurance policy has a lifetime maximum dollar coverage limitation pertaining to the entire benefit package and that such maximum has been reached by the applicant; or

(iii) The applicant must submit documentation that the insurance policy is limited to treatment of a specific disease (e.g., a cancer policy). In addition, the applicant must demonstrate proof of uninsurability as delineated in (1)(f)1.

3. An individual with a health insurance policy other than Medicare does not qualify for TennCare as a "limited benefits" uninsurable if none of the items listed in (1)(f) 2.(i) - (1)(f)2. (iii) are true, even if:

(i) The health insurance policy excludes coverage for a specific service, (e.g., organ transplant, childhood speech therapy, pharmacy services, private duty nursing); or

(ii) The applicant has reached an annual or lifetime limitation for a specific service (e.g., annual limitation on pharmacy services).

4. In order for an individual with Medicare coverage to be eligible for TennCare as a "limited benefits" uninsurable, the applicant must comply with the following criteria, as applicable:

(i) If the applicant has Medicare Part A and Part B and no other health insurance, the applicant must submit a letter of denial of Medicare supplemental insurance coverage from a Medicare supplemental policy insurer.

(ii) If the applicant has Medicare Part A (but not Part B) and no other health insurance, the applicant must demonstrate acceptable proof of uninsurability as specified in Section (1)(f)1. above.

(iii) If the applicant has Medicare Part B (but not Part A) and no other health insurance, the applicant must submit a letter of denial of Medicare supplemental insurance coverage from a Medicare supplemental policy insurer.

(iv) If the applicant has Medicare Part A and Part B and other health insurance, the applicant must submit the documentation specified in (1)(f) 2.(i) - (iii).

(v) If the applicant has Medicare Part A (but not Part B) and other health insurance, the applicant must submit the documentation specified in (1)(f) 2. (i) - (iii).

(Rule 1200-13-12-.03, continued)

(vi) If the applicant has Medicare Part B (but not Part A) and other health insurance, the applicant must submit the documentation specified in (1)(f)2. (i) - (iii).

5. Eligibility for TennCare as a "limited benefits" uninsurable on the basis of a specific exclusion or rider of non-coverage based on a specific preexisting medical condition or category of medical conditions shall not extend past the date on which such exclusion or rider is revoked or is otherwise considered by the insurer to be no longer applicable.

6. If an individual is enrolled in TennCare as a "limited benefits" uninsurable, that enrollee was granted eligibility based on possession of said limited benefit policy. Accordingly, in order to continue TennCare eligibility in this category, the enrollee must maintain the non-TennCare health insurance policy, or a similar policy, in force at the time of TennCare enrollment. Termination of such coverage shall result in termination of TennCare coverage. The enrollee will be given notice of termination, and appeal rights as set out at rule 1200-13-12-.12.

(g) Persons who are eligible for TennCare as uninsured (with the exception of 1200-13-12-.03(1)(b)3., 4., and 5.) shall be allowed to enroll in TennCare only during periods of open enrollment. Beginning January 1, 1994 the Bureau of TennCare shall authorize open enrollment for those persons who did not have access to health insurance through any employer or government sponsored health plan (either directly or through a family member) as of March 1, 1993 (effective October 1, 1994 as of July 1, 1994) and continue to lack such access or who did not have coverage through individually funded non-employer sponsored health insurance, as of March 1, 1993 (effective October 1, 1994 as of July 1, 1994) and continue to lack such access. Persons who enroll during the open enrollment period shall have the option of enrolling in TennCare effective the date TennCare receives their application, subject to approval of the application. Persons who enroll during the open enrollment period retroactive to the application date or later must, as a condition of enrollment, pay all applicable premiums, deductibles and copayments from the effective date of their coverage. Persons who enroll during a period of open enrollment shall not be permitted to enroll retroactively prior to the application date. For persons under age eighteen (18) as specified in rule 1200-13-12-.03(1)(b)4., children under age nineteen (19) as specified in rules 1200-13-12-.03(1)(b)6. and 1200-13-12-.03(1)(c) and dislocated workers and their families as specified in rule 1200-13-12-.03(1)(b)5. above, enrollment shall be effective the date the information on the application has been verified, approved and applicable premiums, if any, are paid. The managed care organization shall not be liable for the cost of any medical care rendered prior to the date of application but shall be responsible for the costs of covered services obtained between the date of application and the date of approval of the application.

The Bureau of TennCare will continually monitor the total number of individuals enrolled in the TennCare program. At the point where total enrollment is 90% of the maximum enrollment cap in any given year, an enrollment priority system will automatically be implemented as follows:

Band	Target	Enrollment
1.	90% to 95% of target	Medicaid/Uninsurable and 150% of poverty or below
2.	95% to 100% of target	Medicaid/Uninsurable

If enrollment stays within band one or band two for more than three months, persons with income above the limit for that band will be allowed to enroll based on date of application until the enrollment percentage reaches the next band.

(Rule 1200-13-12-.03, continued)

(h) Beginning on January 1, 1995, the Bureau of TennCare may authorize additional annual periods of open enrollment for persons who are uninsured. These annual periods of open enrollment, when they occur, will last for a period of ninety (90) days. Persons eligible for enrollment will be persons who did not have access to health insurance through any employer or government sponsored health plan (either directly or through a family member) or who did not have coverage through individually funded, non-employer sponsored health insurance, as of a date in the preceding year to be set by the Bureau of TennCare. For calendar year 1995, the date will be July 1, 1994. The effective date of coverage and payment of premiums shall be as described in 1200-13-12-.03(1)(d). During periods of open enrollment, an enrollment priority system as described in 120013-12-.03(1)(d) will be implemented.

(i) Enrollment shall occur in the order in which applications are received and approved, except as otherwise specified in these rules.

(j) If an enrollee elects family coverage through TennCare, all enrollees in the family shall be enrolled in the same health plan and the same mental health plan.

(k) Enrollees in TennCare shall be given their choice of health plans when possible. Once enrolled, the individual shall remain a member of the designated plan until the following period of open enrollment that occurs after the individual has been enrolled in the health plan for a minimum of twelve (12) consecutive months or until he/she loses eligibility for TennCare, whichever occurs first. During the authorized period of open enrollment of each successive year that an enrollee remains eligible for TennCare, enrollees who have been enrolled in the designated plan for a minimum of twelve (12) consecutive months prior to the period of open enrollment shall be given the opportunity to elect enrollment in a different health plan serving the same community service area. Enrollees who have been enrolled in a health plan for less than twelve (12) consecutive months prior to the period of open enrollment shall not be allowed to enroll in a different health plan serving the same community service area at the first period of open enrollment but shall be required to remain in the designated plan until the following period of open enrollment. However, enrollees, after going through the grievance procedure and obtaining the approval of the TennCare Bureau, may be permitted to change enrollment to a different health plan. In the event that an enrollee elects to change health plans, the enrollee's medical care will be the responsibility of the original health plan until enrollment in the subsequent health plan is deemed complete in accordance with 1200-13-12-.03 (1)(l).

(l) Participants in the TennCare Partners Program shall be assigned by the Bureau of TennCare to a mental health plan for their mental health and substance abuse services. Participants will be permitted to change their assignments only if their established mental health provider is in a different plan from the one to which they have been assigned or if TDMHMR determines the change is necessary as the result of the resolution of a grievance. The Tennessee Department of Mental Health and Mental Retardation shall be responsible for authorizing changes in BHO assignment.

(m) Enrollees shall be accepted regardless of their health condition at the time of enrollment.

(n) Individuals or families determined eligible for TennCare shall select a health plan at the time of application. Because the health plan is responsible for assisting the enrollee in obtaining health care services during the time between the application date and the date of approval, applicants shall seek health care from plan providers beginning with the date of application. Should the application for enrollment not be approved, the plan is not responsible for payment for services provided during that period.

(o) Enrollment shall be effective when the person eligible for enrollment has selected or been assigned to a managed care plan from those available in the area where the person resides, the application has been approved by the Bureau of TennCare, and when any applicable premiums

have been paid. In the event that an individual fails to select a plan, he or she shall be assigned to a plan by the Bureau of TennCare. Enrollment shall be deemed complete retroactive to the date of the original application, if that application is approved. For persons under age eighteen (18) as specified in rule 1200-13-12-.03(1)(b)4., children under age nineteen (19) as specified in rules 1200-13-12-.03(1)(b)6. and 1200-13-12-.03(1)(c) and dislocated workers and their families as specified in rule 1200-13-12-.03(1)(b)5. above, enrollment shall be effective the date the information on the application has been verified, approved and applicable premiums, if any, are paid. Coverage shall begin at 12:01 a.m. on the first day that enrollment is deemed complete.

(p) Managed care organizations shall offer enrollees to the extent possible freedom of choice among providers participating in their respective health plans. If, after notification of enrollment the enrollee has not chosen a primary care provider, one may be chosen for him/her by the managed care organization. When possible an enrollee shall have fifteen (15) calendar days to choose a primary care provider. After February 1, 1994, the period during which an enrollee may choose his primary care provider shall not be less than fifteen (15) calendar days.

(2) DISENROLLMENT FROM A MANAGED CARE ORGANIZATION

(a) An enrollee in the TennCare system may be terminated from a designated health plan only when authorized by the Bureau of TennCare pursuant to these rules.

(b) An enrollee in the TennCare system may be terminated from a designated mental health plan only when authorized by the Bureau of TennCare or the Tennessee Department of Mental Health and Mental Retardation if that function has been delegated to TDMHMR by the Bureau of TennCare.

(c) Coverage shall cease at 12:00 midnight on the date that an individual is disenrolled.

(d) Unacceptable Reasons for Disenrollment

The enrollment of an enrollee in the TennCare system may not be terminated from a designated health plan for any of the following reasons:

1. Adverse changes in the enrollee's health;

2. Pre-existing medical conditions;

3. High cost medical bills; or

4. Failure or refusal to pay applicable deductibles, copayments and/or special fees except when TennCare has approved such disenrollment.

(3) RE-ENROLLMENT

(a) A TennCare enrollee who is not eligible for Medicaid and who is disenrolled due to failure to pay the required premiums shall be required to pay all unpaid premiums in order to be re-enrolled in TennCare. For purposes of this subparagraph, "all unpaid premiums" shall refer to those premiums accrued beginning with the first month of unpaid premiums until the date the Bureau terminated TennCare eligibility. A disenrolled individual must re-apply for TennCare under current eligibility criteria. The application of such an individual shall be processed in the same manner as all other applications.

(b) TennCare enrollees who are not eligible for Medicaid and who are disenrolled because of abuse of TennCare by allowing an ineligible person to utilize the enrollee's TennCare identification

card to obtain services or enrollees who use their TennCare identification card to seek or obtain drugs or supplies illegally or for resale shall not be allowed to re-enroll in TennCare.

(c) TennCare enrollees who are not eligible for Medicaid and who are disenrolled for failure to pay applicable deductibles, copayments and/or special fees may be allowed to re-enroll in TennCare at the next period of open enrollment, provided the amount of any deductibles, copayments and/or special fees for which they were responsible during the preceding period of TennCare eligibility are paid in full. The application of such persons shall be processed in the same manner as all other applications. Persons who re-enroll pursuant to this section shall not be permitted to re-enroll retroactively except to the extent permitted in rule 1200-13-12-.03(1)(d).

(d) TennCare enrollees who are disenrolled from TennCare pursuant to rule 1200-13-12-.03(2) shall be allowed to re-enroll in TennCare at any time if they become Medicaid eligible and shall not be required to pay arrearages as a condition of reenrollment. However, nothing in this provision shall eliminate the enrollee's responsibility for deductibles, copayments or special fees incurred under the previous period of non-Medicaid eligibility.

(e) Non-Medicaid-eligible children under age nineteen (19), whose parental TennCare coverage was terminated due to non-payment of premiums, may re-apply for TennCare. Children under age nineteen (19) shall not be denied TennCare eligibility because of arrearages accumulated by a parent(s). Such application shall be processed in the same manner as all other applications.

(4) REASSIGNMENT

Reassignment to an MCO other than the current plan in which the enrollee is placed is subject to an MCO's capacity to accept new enrollees, must be approved by the Bureau of TennCare, and is the result of one of the following:

(a) During the initial 45-day period of eligibility, an enrollee may request transfer to an MCO other than the one to which he/she was assigned. Effective July 1, 2001, enrollees can make this change in ninety (90) days.

(b) During an annual period in which enrollees are given the opportunity to transfer to another MCO.

(c) An enrollee must change MCOs if he/she moves outside the MCO's community service area (CSA), and that MCO is not authorized to operate in the enrollee's new place of residence. Until an enrollee selects or is assigned to a new health plan and his/her enrollment is deemed complete, his/her medical care will remain the responsibility of the original health plan. Once reassigned, an enrollee will have ninety (90) calendar days to change his/her choice of health plans in the new CSA, effective July 1, 2001.-

(d) Enrollees will be given the opportunity to select a new health plan if their MCO withdraws from participation in TennCare and is no longer available. If the enrollee does not make a selection within the allotted time frame, the Bureau will assign him/her to an MCO operating in their CSA.

Enrollees may change health plans at any time if they have gone through the grievance procedure and have obtained approval from the Bureau of TennCare.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, Executive Order No. 23 of 1997, and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed November 30, 1994; effective February 3, 1995. Amendment filed May 5, 1997; effective July 19, 1997. Amendment filed October 31, 1997; effective January 12, 1998. Amendment filed April 20, 1998; effective July 4, 1998. Amendment filed July 28, 1998; effective October 11, 1998. Amendment filed November 12, 1998; effective*

(Rule 1200-13-12-.03, continued)

January 26, 1999. Amendment filed February 10, 2000; effective April 25, 2000. Amendment filed July 6, 2001; effective September 19, 2001.

1200-13-12-.04 COVERED SERVICES.

(1) TennCare managed care organizations shall cover, at a minimum, the following services and benefits consistent with and in accordance with the Title XIX Medicaid State Plan in existence as of December 31, 1993 and Title XIX CFR requirements governing benefits and Sections 5.01 through 5.03 of Article V of the State of Tennessee Comprehensive Medical and Hospitalization Program Plan Benefits, subject to any applicable limitations described herein. Managed care organizations shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the managed care organization's ability to establish procedures for the determination of medical necessity.

SERVICE	BENEFIT
(a) Inpatient Hospital Days (including days at designated prenatal center)	As medically necessary. Preadmission approval and concurrent reviews by the managed care organization are allowed.
(b) Inpatient Psychiatric Facility Services	
1. Under 21	As medically necessary. Preadmission approval and concurrent reviews by the managed care organization are allowed.
2. Age 21-65	As medically necessary and in accordance with HCFA requirements. Preadmission approval and concurrent reviews by the managed care organization are allowed.
3. Over 65	As medically necessary. Preadmission approval and concurrent reviews by the managed care organization are allowed.
(c) Inpatient Substance Abuse Treatment Program	As medically necessary for children under age 21. As medically necessary for adults subject to the following lifetime limits: $30,000 for inpatient and out-patient substance abuse treatment. Lifetime limit of ten (10) inpatient detox days. This limit shall not apply to persons who are Severely and/or Persistently Mentally Ill or Seriously Emotionally Disturbed.
(d) Outpatient Hospital Services	As medically necessary.
(e) Outpatient Mental Health Services (including physician services)	As medically necessary.
(f) Outpatient Substance Abuse Treatment Program	As medically necessary for children under age 21. As medically necessary for adults subject to the following lifetime limit: $30,000 for

		inpatient and out-patient substance abuse treatment. This limit shall not apply to persons who are Severely and/or Persistently Mentally Ill or Seriously Emotionally Disturbed.
(g)	Physician Inpatient Services	As medically necessary.
(h)	Physician Psychiatric Inpatient Services	As medically necessary.
(i)	Physician Outpatient Services	As medically necessary.
(j)	Lab & X-Ray Services	As medically necessary.
(k)	Hospice Care (must be provided by an organization certified pursuant to Medicare Hospice requirements)	As medically necessary.
(l)	Dental Services	Preventive, diagnostic, and treatment services for enrollees under age 21. Services for enrollees age 21 or older limited to cases of accidental injury to or neoplasms of the oral cavity.
(m)	Vision Services	Preventive, diagnostic, and treatment services for enrollees under age 21.
(n)	Home Health Care	As medically necessary.
(o)	Pharmacy	As medically necessary. Less than effective, IRS drugs excluded.
(p)	Durable Medical Equipment	As medically necessary.
(q)	Medical Supplies	As medically necessary.
(r)	Emergency Ambulance Transportation	As medically necessary.
(s)	Non-Emergency Ambulance Transportation	As medically necessary.
(t)	Non-Emergency Transportation	As medically necessary.
(u)	Community Health Clinic Services	As medically necessary.
(v)	Renal Dialysis Clinic Services	As medically necessary.
(w)	EPSDT Services for Enrollees under age 21	Screening, interperiodic screening, diagnosis and follow-up treatment services as medically necessary for enrollees under age 21 in accordance with Federal regulations as

		described in 42 C.F.R. Part 441, Subpart B and 42 U.S.C. §1396d(r).
(x)	Rehabilitation Services	As medically necessary, when determined to be cost-effective by the managed care organization.
(y)	Chiropractic Services	When determined cost-effective by the managed care organization.
(z)	Reconstructive Breast Surgery	In accordance with T.C.A. §56-7-2507 which requires coverage of all stages of recontructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician.

(2) The managed care organization shall be allowed to use alternative services, whether listed as covered or non-covered, when the use of alternative services is medically appropriate and cost-effective.

(3) The following preventive medical services (identified by applicable CPT procedure codes) shall be covered subject to any limitations described herein, within the scope of standard medical practice, and shall be exempt from any deductibles and copayments as described in 1200-13-12-.05(4).

Dental services and laboratory services not specifically listed herein, which are required pursuant to the Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT) program for persons under age 21, shall be provided in accordance with the TennCare periodicity schedule for such services.

(a) *Office Visits*

1. NEW PATIENT

99381 - Initial evaluation
99382 - age 1 through 4 years
99383 - age 5 through 11 years
99384 - age 12 through 17 years
99385 - age 18 through 39 years
99386 - age 40 through 64 years
99387 - age 65 years and over

2. ESTABLISHED PATIENT

99391 - Periodic reevaluation
99392 - age 1 through 4 years
99393 - age 5 through 11 years
99394 - age 12 through 17 years
99395 - age 18 through 39 years
99396 - age 40 through 64 years
99397 - age 65 years and over

(b) *Counseling and Risk Factor Reduction Intervention*

1. INDIVIDUAL

99401 - approximately 15 minutes
99402 - approximately 30 minutes
99403 - approximately 45 minutes
99404 - approximately 60 minutes

2. GROUP

99411 - approximately 30 minutes
99412 - approximately 60 minutes

(c) *Family Planning Services* if not part of a Preventive Services office visit, should be billed using the codes in (b)1. above.

(d) *Prenatal Care*

59400 Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care

59410 Vaginal delivery only (with or without episiotomy and/or forceps) including postpartum care

59430 Postpartum care only (separate procedure)

59510 Routine obstetric care including antepartum care, cesarean delivery, and postpartum care

59515 Cesarean delivery only including postpartum care

(e) *Other preventive services*

99420 Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)

90700 through 90742 - Immunizations

92551 Screening test, pure tone, air only (Audiologic function)

92552 Pure tone audiometry (threshold); air only

Any laboratory test or procedure listed in the preventive services periodicity schedule when the service CPT code is one of the above preventive medicine codes. This includes mammography screening (76092) as indicated in the periodicity schedule.

(4) MAXIMUM LIFETIME LIMITATIONS: The following maximum lifetime limitations shall apply to the services outlined in paragraphs (1) and (2) above. The managed care organizations shall not impose service limitations that are more restrictive than those described herein but benefits may be provided in excess of these amounts at the managed care organization's discretion. Determination of these limitations shall be based upon the managed care organization's payments for those services and shall exclude payments made by the enrollee in the form of deductibles, copayments, and/or special fees. Persons who are determined to be Seriously and/or Persistently Mentally Ill or Seriously Emotionally Disturbed by TennCare are exempt from limitations on substance abuse services. Children under age 21 are also exempt from limitations on substance abuse services.

Substance abuse benefits $30,000

(inpatient and outpatient)

(5) EMERGENCY MEDICAL SERVICES shall be available twenty-four (24) hours per day, seven (7) days per week. Coverage of emergency medical services shall not be subject to prior authorization by the managed care organization but may include a requirement that notice be given to the managed care organization of use of out-of-plan emergency services. However, such notice requirements shall provide at least a 24 hour time frame after the emergency for notice to be given to the managed care organization.

(6) MANAGED CARE ORGANIZATIONS may offer but are not required to offer certain incentives such as a greater variety and/or quantity of health care services and benefits as a means of promoting enrollment in their respective plans. These incentives must have prior written approval from the Bureau of TennCare.

(7) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) for Individuals Under 21. The Bureau of TennCare, through its contracts with managed care organizations (MCOs), behavioral health organizations (BHOs) and other contractors (also referred to collectively as Contractors), operates an EPSDT program to provide health care services as required by 42 C.F.R. Part 441, Subpart B, and the "Omnibus Budget Reconciliation Act of 1989" to eligible enrollees under the age of 21.

(a) *Responsibilities of the Bureau of TennCare*

1. The Bureau will:

(i) Keep Contractors informed as to changes to the requirements for the operation of the EPSDT program;

(ii) Make changes to the rules of TennCare when necessary to keep the EPSDT program in compliance with federal and state requirements;

(iii) Provide policy clarification when needed; and

(iv) Oversee the activities of the Contractors to assure compliance with all aspects of the EPSDT program.

2. The Bureau, through local health departments, shall inform families of uninsured children who are enrolled in TennCare, of the benefits covered under TennCare and the importance of accessing preventive services.

3. The Bureau, through local health departments, shall provide information on covered services to adolescent prenatal patients who enter TennCare through presumptive eligibility. Assistance will be offered to presumptive eligibles on the day eligibility is determined in making a timely first prenatal appointment; for a woman past her first trimester, this appointment should occur within 15 days.

4. The Bureau, through the Department of Children's Services, shall inform foster parents and institutions or other residential treatment settings with a number of eligible children, annually or more often when the need arises, including when a change of administrators, social workers, or foster parents occur, of the availability of EPSDT services.

(b) *Responsibilities of Contractors*

1. Contractors shall aggressively and effectively inform enrollees of the existence of the EPSDT program, including the availability of specific EPSDT screening and treatment services. Such informing shall occur in a timely manner, generally within 60 days of the

MCO's receipt of notification of the child's enrollment in its plan and if no one eligible in the family has utilized EPSDT services, at least annually thereafter.

Contractors shall document to the Bureau their outreach activities and what efforts were made to inform enrollees and/or their responsible parties about the availability of EPSDT services and how to access such services. Failure to timely submit the requested data may result in liquidated damages as described in the contracts between the Bureau of TennCare and the Contractors.

2. Contractors shall use clear and non-technical terms to provide a combination of written and oral information so that the program is clearly and easily understandable.

3. Contractors shall use effective methods (developed through collaboration with agencies which have established procedures for working with such individuals) to inform individuals who are illiterate, blind, deaf, or cannot understand English, about the availability of EPSDT services.

4. Contractors shall design and conduct outreach to inform all eligible individuals about what services are available under EPSDT, the benefits of preventive health care, where services are available, and how to obtain them; and that necessary transportation and scheduling assistance is available.

5. Contractors shall create a system so that families can readily access an accurate list of names and phone numbers of contract providers who are currently accepting TennCare.

6. Contractors shall offer both transportation and scheduling assistance prior to the due date of the child's periodic examination.

7. Contractors shall provide enrollees assistance in scheduling appointments and obtaining transportation prior to the date of each periodic examination as requested and necessary.

8. Contractors shall document services declined by a parent or guardian or a mature competent child, specifying the particular service declined so that outreach and education for other EPSDT services continues.

9. Contractors shall maintain records of the efforts taken to outreach children who have missed screening appointments when scheduled or who have failed to schedule regular check-ups. These records shall be made available to the Bureau and other parties as directed.

10. Contractors shall inform families of the costs, if any, of EPSDT services.

11. Contractors shall treat a TennCare-eligible woman's request for EPSDT services during pregnancy as a request for EPSDT services for the child at birth.

(c) *Compliance*

Contractors must document and maintain records of all outreach efforts made to inform enrollees about the availability of EPSDT services.

(8) RESERVED.

(9) HOSPITAL DISCHARGES of mothers and newborn babies following delivery shall take into consideration the following guidelines:

(Rule 1200-13-12-.04, continued)

(a) The decision to discharge postpartum mothers and newborns less than 24-48 hours after delivery should be made based upon discharge criteria collaboratively developed and adopted by obstetricians, pediatricians, family practitioners, delivery hospitals, and health plans. The criteria must be contingent upon appropriate preparation, meeting in hospital criteria for both mother and baby, and the planning and implementation of appropriate follow-up. An individualized plan of care must include identification of a primary care provider for both mother and baby and arrangements for follow-up evaluation of the newborn.

Length of hospital stay is only one factor to consider when attempting to optimize patient outcomes for postpartum women and newborns. Excellent outcomes are possible even when length of stay is very brief (less than 24 hours) if perinatal health care is well planned, allows for continuity of care, and patients are well chosen. Some postpartum patients and/or newborns may require extended hospitalization (greater than 48-72 hours) despite meticulous care due to medical, obstetric, or neonatal complications. The decision for time of discharge must be individualized and made by the physicians caring for the mother-baby pair. The following guidelines have been developed to aid in the identification of postpartum mothers and newborns who may be candidates for discharge prior to 24-48 hours. The guidelines also provide examples where discharge is inappropriate.

Principles of patient care should be based upon data obtained by clinical research. Regarding the question of postpartum and newborn length of hospitalization, there are inadequate studies available to provide clear direction for clinical decision making. Clinical guidelines represent an attempt to conceptualize what is, in reality, a dynamic process of health care refinement. Review of these guidelines is desirable and expected.

No provider shall be denied participation, reimbursement or reduction in reimbursement within a network solely related to their compliance with the "Guidelines for Discharge of Postpartum Mothers and Newborns."

(b) Guidelines for Discharge of Postpartum Mothers and Newborns.

1. Discharge Planning.

(i) Discharge planning should occur in a planned and systematic fashion for all postpartum women and newborns in order to enhance care, prevent complications and minimize the need for rehospitalization. Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father if possible) about any expected perinatal problems and ways to cope with them. Plans for future and immediate care as well as instructions to follow in the event of an emergency or complication should be discussed.

Follow-up care must be planned for both mother and baby at the time of discharge. For patients leaving the hospital prior to 24-48 hours, contact within 48-72 hours of discharge is recommended and may include appropriate follow-up within 48-72 hours as deemed necessary by the attending provider, depending upon individual patient need. This follow-up visit will be acknowledged as a provider encounter.

(I) Maternal Considerations:

I. Prior to discharge, the patient should be informed of normal postpartum events including but not limited to:

A. Lochial patterns;

B. Range of activity and exercise;

C. Breast care;

D. Bladder care;

E. Dietary needs;

F. Perineal care;

G. Emotional responses;

H. What to report to physician or other health care provider including:

(A) Elevation of temperature,

(B) Chills,

(C) Leg pains, and

(D) Increased vaginal bleeding.

I. Method of contraception;

J. Coitus resumption; and

K. Specific instructions for follow-up (routine and emergent)

(II) Neonatal Considerations:

I. Prior to discharge, the following points should be reviewed with the mother or, preferably, with both parents:

A. Condition of the neonate;

B. Immediate needs of the neonate; (eg., feeding methods and environmental supports);

C. Instructions to follow in the event of a newborn comp lication or emergency;

D. Feeding techniques: skin care, including cord care and genital care; temperature assessment and measurement with the thermometer; and assessment of neonatal well-being; recognition of illness including jaundice; proper infant safety including use of car seat and sleeping position;

E. Reasonable expectations for the future; and

F. Importance of maintaining immunization begun with initial dose of hepatitis B vaccine.

2. Criteria for Maternal Discharge Less Than 24-48 Hours Following Delivery.

(i) Prior to discharge of the mother, the following should occur:

(I) The mother should have been observed after delivery for a sufficient time to ensure that her condition is stable, that she has sufficiently recovered and may be safely transferred to outpatient care.

(II) Laboratory evaluations should be obtained and include ABO blood group and Rh typing with appropriate use of Rh immune globulin; and hematocrit or hemoglobin.

(III) The mother should have received adequate preparation for and be able to assume self and immediate neonatal care.

(ii) Factors which may exclude maternal discharge prior to 24-48 hours include:

(I) Abnormal bleeding.

(II) Fever equal to or greater than 100.4 degrees.

(III) Inadequate or no prenatal care.

(IV) Cesarean section.

(V) Untreated or unstable maternal medical condition.

(VI) Uncontrolled hypertension.

(VII) Inability to void.

(VIII) Inability to tolerate solid foods.

(IX) Adolescent mother without adequate support and where appropriate follow-up has not been established. A nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

(X) All efforts should be made to keep mother and infant together to ensure simultaneous discharge.

(XI) Psychosocial problems (maternal or family) which have been identified prenatally or in hospital. Where appropriate follow-up has not been established, a nurse home visit within 24-48 hours of discharge would act as appropriate follow-up.

3. Criteria for Neonatal, Discharge Less than 24-48 Hours Following Delivery.

(i) The nursery stay is planned to allow the identification of early problems and to reinforce instruction in preparation for care of the infant at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth there is an element of medical risk in early neonatal discharge. Most problems are manifest during the first 12 hours, and discharge at or prior to 24 hours is appropriate for many newborns.

(I) Prior to discharge of the newborn at 24-48 hours, the following should have occurred:

(Rule 1200-13-12-.04, continued)

I. The course of antepartum, intrapartum, and postpartum care for both mother and fetus should be without problems which may lead to newborn complications.

II. The baby is a single birth at 37 to 42 weeks' gestation and the birth weight is appropriate for gestational age according to appropriate intrauterine growth curves.

III. The baby's vital signs are documented as being normal and stable for the 12 hours preceding discharge, including a respiratory rate below 60/minute, a heart rate of 100 to 160 beats per minute, and an axillary temperature of 36.1 degrees C in an open crib with appropriate clothing.

IV. The baby has urinated and passed at least one stool.

V. No evidence of excessive bleeding after circumcision greater than 2 hours.

VI. The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding.

VII. No evidence of significant jaundice in the first 24 hours of life.

VIII. The parent's or caretaker's knowledge, ability, and confidence to provide adequate care for her baby are documented.

IX. Laboratory data are available and reviewed including:

A. Maternal syphilis and hepatitis B surface antigen status.

B. Cord or infant blood type and direct Coomb's test result as clinically indicated.

X. Screening tests are performed in accordance with state regulations. If the test is performed before 24 hours of milk feeding, a system for repeating the test must be assured during the follow-up visit.

XI. Initial hepatitis B vaccine is administered or a scheduled appointment for its administration has been made.

XII. A physician-directed source of continuing medical care for both the mother and the baby is identified. For newborns discharged less than 24-48 hours after delivery, a definitive plan for contact within 48-72 hours after discharge has been made. A nurse home visit within 24-48 hours would be considered appropriate follow-up.

(II) Maternal factors which may exclude discharge of the newborn prior to 24-48 hours include:

I. Inadequate or no prenatal care,

II. Medical conditions that pose a significant risk to the infant,

(Rule 1200-13-12-.04, continued)

III. Group B streptococcus colonization,

IV. Untreated syphilis,

V. Suspected active genital herpes,

VI. HIV,

VII. Adolescent without adequate support and where appropriate follow-up has not been established (a nurse home visit within 24-48 hours of discharge will act as appropriate follow-up),

VIII. Mental retardation or psychiatric illness, and

IX. Requirements for continued maternal hospitalization.

(III) Newborn factors which may exclude discharge of the newborn prior to 24-48 hours include:

I. Preterin gestation (less than 37 weeks);

II. Small for gestational age;

III. Large for gestational age;

IV. Abnormal physical exam, vital signs, color, activity, feeding or stooling;

V. Significant congenital malformations; and

VI. Abnormal laboratory finding:

A. Hypoglycemia,

B. Hyperbilirubinemia,

C. Polycythemia,

D. Anemia, and

E. Rapid plasma reagin positive.

Authority: *T.C.A. §§4-4-117; 4-5-202; 71-5-105; 71-5-109, Executive Order No. 11 of 1997, and Executive Order No. 23. of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed August 6, 1996; effective October 20, 1996. Amendment filed May 5, 1997; effective July 19, 1997. Amendment filed July 14, 1998; effective September 27, 1998. Amendment filed October 14, 1998; effective December 28, 1998. Amendment filed March 22, 1999; effective June 5, 1999. Amendment filed February 23, 2001; effective May 9, 2001.*

1200-13-12-.05 ENROLLEE COST SHARING

(1) For persons who are TennCare eligible as uninsured or uninsurable and whose income is equal to or greater than 100% of the 1998 federal poverty level, the following schedule of premiums shall apply.

Except as described in rule 1200-13-12-.05 (3)(a) and (3)(b), the annual deductible amo unt shall be $250 for an individual or $500 for a family. Effective January 1, 1998, the annual deductible amount for children under age nineteen (19) whose family income is below two hundred percent (200%) of the federal poverty level schedule in effect for calculation of TennCare premiums shall be $0.00. The maximum annual out-of-pocket expenses shall be $1,000 for individuals or $2,000 for a family.

(a) Effective January 1, 1999, TennCare Premium Sliding Scale (uninsured)

Individual Monthly Premium	$0	$15.11	$18.55	$24.91	$34.71
Family Monthly Premium	$0	$25.97	$34.19	$50.35	$74.73
Percentage of Poverty	0% - 100%	101% - 119%	120% - 139%	140% - 169%	170% - 199%
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	0 - 677	678 - 804	805 - 938	939 - 1,140	1,141 - 1,341
2	0 - 912	913 - 1,084	1,085 - 1,265	1,266 - 1,536	1,537 - 1,807
3	0 - 1,148	1,149 - 1,365	1,366 - 1,592	1,593 - 1,934	1,935 - 2,275
4	0 - 1,384	1,385 - 1,644	1,645 - 1,918	1,919 - 2,330	2,331 - 2,741
5	0 - 1,619	1,620 - 1,924	1,925 - 2,245	2,246 - 2,726	2,727 - 3,207
6	0 - 1,855	1,856 - 2,205	2,206 - 2,572	2,573 - 3,124	3,125 - 3,675
7	0 - 2,091	2,092 - 2,484	2,485 - 2,898	2,899 - 3,520	3,521 - 4,141
8	0 - 2,326	2,327- 2,764	2,765 - 3,225	3,226 - 3,916	3,917 - 4,607
9	0 - 2,562	2,563 – 3,045	3,046 - 3,552	3,553 - 4,314	4,315 – 5,075
10*	0 - 2,798	2,799 - 3,324	3,325 - 3,878	3,879 - 4,710	4,711 - 5,541
*For each family member over 10, add per month	0 - 234	235-279	280 - 325	326 - 395	396 - 465

(Rule 1200-13-12-.05, continued)

Individual Monthly Premium	$77.91	$85.33	$93.02	$104.68	$116.34
Family Monthly Premium	$194.51	$212.80	$232.41	$261.56	$290.44
Percentage of Poverty	200% - 209%	210% - 219%	220% - 239%	240% - 269%	270% - 299%
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	1,342 - 1,408	1,409 - 1,475	1,476 - 1,609	1,610 - 1,811	1,812 – 2,012
2	1,808 - 1,897	1,898 - 1,988	1,989 - 2,169	2,170 - 2,440	2,441 - 2,711
3	2,276 - 2,389	2,390 - 2,503	2,504 - 2,730	2,731 – 3,072	3,073 - 3,413
4	2,742 - 2,878	2,879 – 3,015	3,016 - 3,289	3,290 - 3,701	3,702 - 4,112
5	3,208 - 3,367	3,368 - 3,528	3,529 - 3,849	3,850 - 4,330	4,331 - 4,811
6	3,676 - 3,859	3,860 – 4,043	4,044 - 4,410	4,411 - 4,962	4,963 - 5,513
7	4,142 - 4,348	4,349 – 4,555	4,556 - 4,969	4,970 - 5,591	5,592 - 6,212
8	4,608 - 4,837	4,838 – 5,068	5,069 - 5,529	5,530 - 6,220	6,221- 6,911
9	5,076 - 5,329	5,330- 5,583	5,584 – 6,090	6,091 - 6,852	6,853 - 7,613
10*	5,542 - 5,818	5,819 – 6,095	6,096 - 6,649	6,650 - 7,481	7,482 - 8,312
*For each family member over 10, add per month	466 - 488	489 - 512	513 - 558	559 - 628	629 - 698

Individual Monthly Premium	$135.68	$155.29	$195.84	$201.67
Family Monthly Premium	$339.20	$387.70	$489.19	$504.03
Percentage of Poverty	300% - 349%	350% - 399%	400% - 749%	750% - Over
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	2,013 - 2,348	2,349 - 2,683	2,684 – 5,032	5,033 - Over
2	2,712 - 3,163	3,164 - 3,615	3,616 - 6,779	6,780 - Over
3	3,414 - 3,982	3,983 - 4,551	4,552 - 8,534	8,535 - Over
4	4,113 - 4,798	4,799 - 5,483	5,484 - 10,282	10,283 - Over
5	4,812 - 5,613	5,614 - 6,415	6,416 – 12,029	12,030 - Over
6	5,514 - 6,432	6,433 - 7,351	7,352 - 13,784	13,785 - Over
7	6,213 - 7,248	7,249 - 8,283	8,284 - 15,532	15,533- Over
8	6,912 – 8,063	8,064 – 9,215	9,216 – 17,279	17,280 - Over
9	7,614 - 8,882	8,883 – 10,151	10,152 – 19,034	19,035 - Over
10*	8,313 - 9,698	9,699 – 11,083	11,084 - 20,782	20,783 - Over
*For each family member over 10, add per month	699 - 815	816 - 931	932 - 1,747	1,748 - Over

(b) Effective January 1, 1999, TennCare Premium Sliding Scale (uninsurable)

(Rule 1200-13-12-.05, continued)

Individual Monthly Premium	$0	$15.11	$18.55	$24.91	$34.71
Family Monthly Premium	$0	$25.97	$34.19	$50.35	$74.73
Percentage of Poverty	0% - 100%	101% - 119%	120% - 139%	140% - 169%	170% - 199%
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	0 - 677	678 - 804	805 - 938	939 - 1,140	1,141 - 1,341
2	0 - 912	913 - 1,084	1,085 - 1,265	1,266 - 1,536	1,537 - 1,807
3	0 - 1,148	1,149 - 1,365	1,366 - 1,592	1,593 - 1,934	1,935 - 2,275
4	0 - 1,384	1,385 - 1,644	1,645 - 1,918	1,919 - 2,330	2,331 - 2,741
5	0 - 1,619	1,620 - 1,924	1,925 - 2,245	2,246 - 2,726	2,727 - 3,207
6	0 - 1,855	1,856 - 2,205	2,206 - 2,572	2,573 - 3,124	3,125 - 3,675
7	0 - 2,091	2,092 - 2,484	2,485 - 2,898	2,899 - 3,520	3,521 - 4,141
8	0 - 2,326	2,327- 2,764	2,765 - 3,225	3,226 - 3,916	3,917 - 4,607
9	0 - 2,562	2,563 – 3,045	3,046 - 3,552	3,553 - 4,314	4,315 – 5,075
10*	0 - 2,798	2,799 - 3,324	3,325 - 3,878	3,879 - 4,710	4,711 - 5,541
*For each family member over 10, add per month	0 - 234	235-279	280 - 325	326 - 395	396 - 465

Individual Monthly Premium	$77.91	$85.33	$93.02	$104.68	$116.34
Family Monthly Premium	$194.51	$212.80	$232.41	$261.56	$290.44
Percentage of Poverty	200% - 209%	210% - 219%	220% - 239%	240% - 269%	270% - 299%
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	1,342 - 1,408	1,409 - 1,475	1,476 - 1,609	1,610 - 1,811	1,812 – 2,012
2	1,808 - 1,897	1,898 - 1,988	1,989 - 2,169	2,170 - 2,440	2,441 - 2,711
3	2,276 - 2,389	2,390 - 2,503	2,504 - 2,730	2,731 – 3,072	3,073 - 3,413
4	2,742 - 2,878	2,879 – 3,015	3,016 - 3,289	3,290 - 3,701	3,702 - 4,112
5	3,208 - 3,367	3,368 - 3,528	3,529 - 3,849	3,850 - 4,330	4,331 - 4,811
6	3,676 - 3,859	3,860 – 4,043	4,044 - 4,410	4,411 - 4,962	4,963 - 5,513
7	4,142 - 4,348	4,349 – 4,555	4,556 - 4,969	4,970 - 5,591	5,592 - 6,212
8	4,608 - 4,837	4,838 – 5,068	5,069 - 5,529	5,530 - 6,220	6,221- 6,911
9	5,076 - 5,329	5,330- 5,583	5,584 – 6,090	6,091 - 6,852	6,853 - 7,613
10*	5,542 - 5,818	5,819 – 6,095	6,096 - 6,649	6,650 - 7,481	7,482 - 8,312
*For each family member over 10, add per month	466 - 488	489 - 512	513 - 558	559 - 628	629 - 698

(Rule 1200-13-12-.05, continued)

Individual Monthly Premium	$135.68	$155.29	$238.50	$245.39
Family Monthly Premium	$339.20	$387.70	$595.72	$613.48

Percentage of Poverty	300% - 349%	350% - 399%	400% - 749%	750% - Over
Family Size	**Monthly Income**	**Monthly Income**	**Monthly Income**	**Monthly Income**
1	2,013 - 2,348	2,349 - 2,683	2,684 – 5,032	5,033 - Over
2	2,712 - 3,163	3,164 - 3,615	3,616 - 6,779	6,780 - Over
3	3,414 - 3,982	3,983 - 4,551	4,552 - 8,534	8,535 - Over
4	4,113 - 4,798	4,799 - 5,483	5,484 - 10,282	10,283 - Over
5	4,812 - 5,613	5,614 - 6,415	6,416 – 12,029	12,030 - Over
6	5,514 - 6,432	6,433 - 7,351	7,352 - 13,784	13,785 - Over
7	6,213 - 7,248	7,249 - 8,283	8,284 - 15,532	15,533- Over
8	6,912 – 8,063	8,064 – 9,215	9,216 – 17,279	17,280 - Over
9	7,614 - 8,882	8,883 – 10,151	10,152 – 19,034	19,035 - Over
10*	8,313 - 9,698	9,699 – 11,083	11,084 - 20,782	20,783 - Over
*For each family member over 10, add per month	699 - 815	816 - 931	932 - 1,747	1,748 - Over

(c) Effective July 1, 2001, the Bureau will implement the TennCare Premium Sliding Scale Schedule as approved by the Centers for Medicare and Medicaid Services, based on the 1999 poverty levels, and it shall apply for both the uninsured and uninsurable designations.

Individual Monthly Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Monthly Premium	$0	$40.00	$70.00	$250.00	$375.00

Percentage of Poverty	0% - 100%	101% - 149%	150% - 199%	200% - 249%	250% - 299%
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	$ 0 - $687	$688 - $1,030	$1,031 - $1,373	$1,374 - $1,717	$1,718 - $2,060
2	$ 0 - $922	$923 - $1,382	$1,383 - $1,843	$1,844 - $2,304	$2,305 - $2,765
3	$ 0 - $1,157	$1,158 - $1,735	$1,736 - $2,313	$2,314 - $2,892	$2,893 - $3,470
4	$ 0 - $1,392	$1,393 - $2,087	$2,088 - $2,783	$2,784 - $3,479	$3,480 - $4,175
5	$ 0 - $1,627	$1,628 - $2,440	$2,441 - $3,253	$3,254 - $4,067	$4,068 - $4,880
6	$ 0 - $1,862	$1,863 - $2,792	$2,793 - $3,723	$3,724 - $4,654	$4,655 - $5,585
7	$ 0 - $2,097	$2,098 - $3,145	$3,146 - $4,193	$4,194 - $5,242	$5,243 - $6,290
8	$ 0 - $2,332	$2,333 - $3,497	$3,498 - $4,663	$4,664 - $5,829	$5,830 - $6,995
9	$ 0 - $2,567	$2,568 - $3,850	$3,851 - $5,133	$5,134 - $6,417	$6,418 - $7,700
10*	$ 0 - $2,802	$2,803 - $4,202	$4,203 - $5,603	$5,604 - $7,004	$7,005 - $8,405
*FOR EACH FAMILY MEMBER OVER 10 ADD PER MONTH	$0 - $234	$235 - $352	$353 - $469	$470 - $587	$588 - $704

(Rule 1200-13-12-.05, continued)

Individual Monthly Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Monthly Premium	$500.00	$625.00	$875.00	$1,125.00	$1,375.00

Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	$2,061 - $2,404	$2,405 - $2,747	$2,748 - $3,434	$3,435 - $4,121	$4,122 - Over
2	$2,766 - $3,226	$3,227 - $3,687	$3,688 - $4,609	$4,610 - $5,531	$5,532 - Over
3	$3,471 - $4,049	$4,050 - $4,627	$4,628 - $5,784	$5,785 - $6,941	$6,942 - Over
4	$4,176 - $4,871	$4,872 - $5,567	$5,568 - $6,959	$6,960 - $8,351	$8,352 - Over
5	$4,881 - $5,694	$5,695 - $6,507	$6,508 - $8,134	$8,135 - $9,761	$9,762 - Over
6	$5,586 - $6,516	$6,517 - $7,447	$7,448 - $9,309	$9,310 - $11,171	$11,172 - Over
7	$6,291 - $7,339	$7,340 - $8,387	$8,388 - $10,484	$10,485 - $12,581	$12,582 - Over
8	$6,996 - $8,161	$8,162 - $9,327	$9,328 - $11,659	$11,660 - $13,991	$13,992 - Over
9	$7,701 - $8,984	$8,985 - $10,267	$10,268 - $12,834	$12,835 - $15,401	$15,402 - Over
10*	$8,406 - $9,806	$9,807 - $11,207	$11,208 - $14,009	$14,010 - $16,811	$16,812 - Over
*FOR EACH FAMILY MEMBER OVER 10 ADD PER MONTH	$705 - $822	$823 - $939	$940 - $1,174	$1,175 - $1,409	$1,410 - Over

(d) Effective January 1, 2002, the Bureau will update its Premium Sliding Scale Schedule monthly income brackets used for the determination of enrollee cost sharing to reflect the most current poverty levels as published by the Centers for Medicare and Medicaid Services. The Premium Sliding Scale effective January 1, 2002, follows:

Individual Monthly Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Monthly Premium	$0	$40.00	$70.00	$250.00	$375.00

Percentage of Poverty	0% - 100%	101% - 149%	150% - 199%	200% - 249%	250% - 299%
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	$ 0 - $716	$717 - $1,073	$1,074 - $1,431	$1,432 - $1,789	$1,790 - $2,147
2	$ 0 - $968	$969 - $1,451	$1,452 - $1,935	$1,936 - $2,419	$2,420 - $2,903
3	$ 0 - $1,219	$1,220 - $1,828	$1,829 - $2,437	$2,438 - $3,047	$3,048 - $3,656
4	$ 0 - $1,471	$1,472 - $2,206	$2,207 - $2,941	$2,942 - $3,677	$3,678 - $4,412
5	$ 0 - $1,723	$1,724 - $2,584	$2,585 - $3,445	$3,446 - $4,307	$4,308 - $5,168
6	$ 0 - $1,974	$1,975 - $2,960	$2,961 - $3,947	$3,948 - $4,934	$4,935 - $5,921
7	$ 0 - $2,226	$2,227 - $3,338	$3,339 - $4,451	$4,452 - $5,566	$5,567 - $6,677
8	$ 0 - $2,478	$2,479 - $3,716	$3,717 - $4,955	$4,956 - $6,194	$6,195 - $7,433
9	$ 0 - $2,730	$2,731 - $4,094	$4,095 - $5,459	$5,460 - $6,824	$6,825 - $8,189
10*	$ 0 - $2,982	$2,983 - $4,472	$4,473 - $5,963	$5,964 - $7,454	$7,455 - $8,945

(Rule 1200-13-12-.05, continued)

*FOR EACH FAMILY MEMBER OVER 10 ADD PER MONTH	$0 - $252	$253 - $378	$379 - $503	$504 - $629	$630 - $755
Individual Monthly Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Monthly Premium	$500.00	$625.00	$875.00	$1,125.00	$1,375.00

Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Family Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	$2,148 - $2,505	$2,506 - $2,863	$2,864 - $3,579	$3,580 - $4,295	$4,296 - Over
2	$2,904 - $3,387	$3,388 - $3,871	$3,872 - $4,839	$4,840 - $5,807	$5,808 - Over
3	$3,657 - $4,266	$4,267 - $4,875	$4,876 - $6,094	$6,095 - $7,313	$7,314 - Over
4	$4,413 - $5,148	$5,149 - $5,883	$5,884 - $7,354	$7,355 - $8,825	$8,826 - Over
5	$5,169 - $6,030	$6,031 - $6,891	$6,892 - $8,614	$8,615 - $10,337	$10,338 - Over
6	$5,922 - $6,908	$6,909 - $7,895	$7,896 - $9,869	$9,870 - $11,843	$11,844 - Over
7	$6,678 - $7,790	$7,791 - $8,903	$8,904 - $11,129	$11,130 - $13,355	$13,356 - Over
8	$7,434 - $8,672	$8,673 - $9,911	$9,912 - $12,389	$12,390 - $14,867	$14,868 - Over
9	$8,190 - $9,554	$9,555 - $10,919	$10,920 - $13,649	$13,650 - $16,379	$16,380 - Over
10*	$8,946 - $10,436	$10,437 - $11,927	$11,928 - $14,909	$14,910 - $17,891	$17,892 - Over

*FOR EACH FAMILY MEMBER OVER 10 ADD PER MONTH	$756 - $881	$882 - $1,007	$1,008 - $1,259	$1,260 - $1,511	$1,512 - Over

(e) The Bureau of TennCare will annually review and revise as appropriate, the premiums that the uninsured and uninsurable enrollees are required to pay based on income and family size, as approved by the Centers for Medicare and Medicaid Services.

(f) Notice will be given to enrollees prior to the imp lementation of changes to the TennCare Sliding Scale Premium Schedule as the result of changes to the poverty levels used and/or changes in the amount of monthly premiums.

(2) Individuals determined eligible for TennCare and who are required to pay premiu ms will be sent a notice indicating the amount of the premium and the date the premium must be received in order to be enrolled in TennCare. Once the initial premium is received, premium payments for succeeding months must be received by the Bureau of TennCare by the first day of the month for which health care coverage is to be provided. If the payment is not received by the fifth day of the month, the individual will be sent a notice of delinquency. The individual will be notified that if payment is received within sixty (60) calendar days of the date of the notice, coverage will be continued without interruption. If payment is not received within the sixty (60) calendar days, the individual will be involuntarily disenrolled from TennCare. The individual may re-apply for TennCare at the next period of open enrollment.

(Rule 1200-13-12-.05, continued)

(3) In accordance with the following schedules, families and individuals who enroll in TennCare, who are not Medicaid-eligible, and whose income exceeds 100% of the 1998 federal poverty level shall pay deductibles and copayments to their managed care organizations in accordance with the timeframes established by the managed care organization for services other than preventive services. Effective January 1, 1998, the annual deductible amount for children under age nineteen (19) whose family income is above 100% but less than two hundred percent (200%) of the federal level schedule in effect for calculation of TennCare premiums shall be $0.00 and the copayment amount shall be two percent (2%).

(a) Effective January 1, 2000, or at such date thereafter as the change is approved by the Health Care Financing Administration and can be implemented, the TennCare deductible for children, individuals and families shall be $ 0.00. The annual TennCare Maximum Out-of-Pocket Expenditures described below shall apply for both uninsured and uninsurable designations, based on the poverty level specified in rule 1200-13-12-.05(1)(c):

TennCare Maximum Annual Out-of-Pocket Expenditures

POVERTY LEVELS	Individual Maximum Annual Out-of-Pocket	Family Maximum Annual Out-of-Pocket
0% - 100%	$ 0.00	$ 0.00
101% - 199%	$ 1,000.00	$ 2,000.00
200% and above	$ 2,000.00	$ 4,000.00

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

(b) Effective January 1, 2000, or at such date thereafter as the change is approved by the Health Care Financing Administration and can be implemented, the following TennCare copayment schedule shall apply for both Uninsured and Uninsurable designations, based on the poverty level specified in rule 1200-13-12-.05(1)(c):

TennCare Copayment Amounts

POVERTY LEVELS	COPAYMENT AMOUNTS
0% - 100%	$ 0.00
101% - 199%	$ 25.00 for hospital emergency room (waived if admitted) $ 5.00 for primary care provider and Community Mental Health Agency services other than preventive care $ 15.00 for physician specialists $ 5.00 for prescription or refill $ 100.00 per inpatient hospital admission
200% and above	$ 50.00 for hospital emergency room (waived if admitted) $ 10.00 for primary care provider and Community Mental Health Agency services other than preventive care $ 25.00 for physician specialists $ 10.00 for prescription or refill

(Rule 1200-13-12-.05, continued)

	$ 200.00 per inpatient hospital admission

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision.

(c) Mental Health Copayments for Outpatient Mental Health Services (including Physician Services) shall be subject to the TennCare copayments required under rule 1200-13-12-.05(3)(b).

(d) Covered preventive services as described in rule 1200-13-12-.04(3) are exempt from any deductibles and copayments.

(e) Enrollees who receive financial settlements, awards or judgments as the result of accidents or negligence shall have their premiums, copayments, and deductible(s) adjusted retroactively to the date of the incident resulting in the settlement.

Authority: *T.C.A. §§ 4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23 of 1997.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed August 6, 1996; effective October 20, 1996. Amendment filed October 8, 1996; effective January 1, 1997. Amendment filed May 5, 1997; effective July 19, 1997. Amendment filed July 28, 1998; effective October 11, 1998. Amendment filed October 15, 1998; effective December 29, 1998. Amendment filed October 23, 2000; effective January 6, 2001. Amendment filed January 9, 2002; effective March 25, 2002.*

1200-13-12-.06 MANAGED CARE ORGANIZATIONS. Managed care organizations participating in TennCare will be limited to Health Maintenance Organizations that are appropriately licensed to operate within the state of Tennessee and Preferred Provider Organizations approved by the Bureau of TennCare to provide medical services in the TennCare program. Managed Care Organizations shall have a fully executed contract with the Tennessee Department of Finance and Administration and Tennessee Department of Mental Health and Mental Retardation, as applicable, and shall agree to comply with all applicable rules, policies and contract requirements as specified by the Tennessee Department of Finance and Administration and Tennessee Department of Mental Health and Mental Retardation, as applicable. Managed care organizations must continually demonstrate a sufficient provider network based on the standards set by the Bureau of TennCare to remain in the program, and must reasonably meet all quality of care requirements established by the Bureau of TennCare.

Authority: *T.C.A. §§4-4-117, 4-5-202, 71-5-105, 71-5-109, Executive Order No. 11 of 1997, and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed May 5, 1997; effective July 19, 1997. Amendment filed July 6, 2001; effective September 19, 2001.*

1200-13-12-.07 MANAGED CARE ORGANIZATION PAYMENT. Payment shall be made to each enrolled managed care organization on a monthly basis for the organization's satisfactory performance of its duties and responsibilities as specified in the contract between the organization and the Tennessee Department of Finance and Administration. Payment shall be based on an established capitation rate divided by the number of days in the month and multiplying this quotient by the total number of enrollee days for the month. The capitation rate will not include costs for long term care or Medicare crossover payments. The state will each month withhold up to ten percent (10%) of each managed care organization's payment pending the following assurances:

(1) All quality of care standards as specified in the contract are met:

(2) All other requirements are met.

The withheld amount shall be distributed back on a monthly basis to the managed care organization if and when the organization's compliance with such standards and requirements is established.

(Rule 1200-13-12-.07, continued)

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, Public Chapter 358 of the "Acts of 1993", and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed July 6, 2001; effective September 19, 2001.*

1200-13-12-.08 PROVIDERS.

(1) In situations where a managed care organization authorizes a service rendered by a provider who is not under contract with the managed care organization, payment to the provider cannot be less than the amount that would have been paid to a provider under contract with the managed care organization for the same service. As a condition of payment, non-contract providers shall accept payment from managed care organizations as payment in full except for applicable deductibles, co-payments and special fees.

(2) Participation in the TennCare program will be limited to providers who:

(a) Accept, as payment in full, the amounts paid by the managed care organization, including enrollee cost-sharing, or the amounts paid in lieu of the managed care organization by a third party (Medicare, insurance, etc.);

(b) Maintain Tennessee, or the State in which they practice, medical licenses and/or certifications as required by their practice, or licensure by the Tennessee Department of Mental Health and Mental Retardation, if appropriate;

(c) Are not under a federal Drug Enforcement Agency (DEA) restriction of their prescribing and/or dispensing certification for scheduled drugs (relative to physicians, osteopaths, dentists and pharmacists);

(d) Agree to maintain and provide access to TennCare and/or its agent all TennCare enrollee medical records for five (5) years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter;

(e) Provide medical assistance at or above recognized standards of practice; and

(f) Comply with all contractual terms between the provider and the managed care organization and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletins.

(g) Failure to comply with any of the above provisions (a) through (f) may subject a provider to the following actions:

1. Sanctions set out in *T.C.A. §71-5-118.* In addition, the provider may be subject to stringent review/audit procedures which may include clinical evaluation of services and a prepayment requirement for documentation and justification for each claim.

2. The Bureau of TennCare may withhold or recover payments to managed care organizations in cases of provider fraud, willful misrepresentation, or flagrant non-compliance with contractual requirements and/or TennCare policies.

3. The Bureau of TennCare may refuse to approve or may suspend provider participation with a provider if any person who has an ownership or controlling interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the U.S. Title XX Services Program.

4. The Bureau of TennCare may refuse to approve or may suspend provider participation if it determines that the provider did not fully and accurately make any disclosure of any person who has ownership or controlling interest in the provider, or is an agent or managing employee of the provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the U.S. Title XX Services Program since the inception of these programs.

5. The Bureau of TennCare shall refuse to approve or shall suspend provider participation if the appropriate State Board of Licensing or Certification fails to license or certify the provider at any time for any reason or suspends or revokes a license or certification.

6. The Bureau of TennCare shall refuse to approve or shall suspend provider participation upon notification by the U.S. Office of Inspector General Department of Health and Human Services that the provider is not eligible under Medicare or Medicaid for federal financial participation.

7. The Bureau of TennCare may recover from a managed care organization any payments made by an enrollee and/or his family for a covered service, in total or in part, except as permitted. If a provider knowingly bills an enrollee and/or his family for a covered service, in total or in part, except as permitted, the Bureau of TennCare may terminate the provider's participation in TennCare.

(3) Solicitations and Referrals

(a) Managed care organizations and providers shall not solicit TennCare enrollees by any method offering as enticements other goods and services (free or otherwise) for the opportunity of providing the enrollee with TennCare covered services that are not medically necessary and/or that overutilize the TennCare program.

(b) A managed care organization may request a waiver from this restriction in writing to TennCare. TennCare shall determine the value of a waiver request based upon the medical necessity and need for the solicitation. The managed care organization may implement the solicitation only upon receipt of a written waiver approval from TennCare. This waiver is not transferable and may be canceled by TennCare upon written notice.

(c) TennCare payments for services related to a non-waivered solicitation enticement shall be considered by TennCare as a non-covered service and recouped. Neither the managed care organization nor the provider may bill the enrollee for non-covered services recouped under this authority.

(d) A provider shall not offer or receive remuneration in any form related to the volume or value of referrals made or received from or to another provider.

(4) Providers may seek payment from a TennCare enrollee if the services are not covered by TennCare and the provider informed the enrollee the services were not covered prior to providing the service.

(5) Providers may not seek payment from a TennCare enrollee under the following conditions:

(a) The provider knew or should have known about the patient's TennCare eligibility or pending eligibility prior to providing services.

(b) The claim(s) submitted to TennCare or the enrollee's managed care organization for payment was denied due to provider billing error or a TennCare claim processing error.

(Rule 1200-13-12-.08, continued)

(c) The provider accepted TennCare assignment on a claim and it is determined that another pay or paid an amount equal to or greater than the TennCare allowable amount.

(d) The provider failed to comply with TennCare policies and procedures or provided a service which lacks medical necessity or justification.

(e) The provider failed to submit or resubmit claims for payment within the time periods required by the managed care organization or TennCare.

(f) The provider failed to ascertain the existence of TennCare eligibility or pending eligibility prior to providing non-emergency services.

(g) The provider failed to inform the enrollee prior to providing a service not covered by TennCare that the service was not covered and the enrollee may be responsible for the cost of the service. Services which are non-covered by virtue of exceeding limitations are exempt from this requirement and shall be governed by rule 1200-13-1-.05(1)(c)2.

(h) The enrollee failed to keep a scheduled appointment(s).

(6) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided if the provider informs the person they will not accept TennCare assignment whether or not eligibility is established retroactively.

(7) Providers may seek payment from a person whose TennCare eligibility is pending at the time services are provided, however, all monies collected must be refunded when a claim is submitted to TennCare if the provider agreed to accept TennCare assignment once retroactive TennCare eligibility was established.

(8) Providers of inpatient hospital services, outpatient hospital services, skilled nursing facility services, independent laboratory and x-ray services, hospice services, and home health agencies must be approved for Title XVIII-Medicare in order to be certified as providers under the TennCare Program; in the case of hospitals, the hospital must meet state licensure requirements and be approved by TennCare as an acute care hospital as of the date of enrollment in TennCare. Children's hospitals and State mental hospitals may participate in TennCare without having been Medicare approved; however, they must be approved by the Joint Commission for Accreditation of Health Care Organizations as a condition of participation.

(9) Effective with the implementation of TennCare, provisions will be made for unallocated fund pool (UFP) payments subject to the availability of funds and the ability of the state to provide adequate matching funds to generate Federal Financial Participation.

(a) Funding availability of the UFP will be calculated as follows:

1. The budgeted TennCare estimated enrollees for each year will be compared to the actual number of enrollees. Any difference may be used for the unallocated fund pool, subject to the availability of funds.

2. The difference between the actual number enrolled and the estimated number enrolled will be multiplied times the budgeted average monthly capitation rate payable to the MCOs (excluding any supplemental capitation payments), creating the UFP funding availability, if sufficient state matching funds are available for this purpose.

(b) The unallocated fund pool payments consist of six components. They are:

(Rule 1200-13-12-.08, continued)

1. Medicaid education payments to certain essential hospital providers identified in (9)(d)1.(i)-(v), if they previously received those payments under the Medicaid program;

2. Payments to essential providers identified in (9)(d)1.(i)-(v) and (9)(d)2. of this section for services provided to individuals eligible for TennCare but not enrolled;

3. Payments to managed care organizations for the first thirty (30) days of care for uninsured or uninsurable TennCare enrollees;

4. Payments to managed care organizations, should it be determined by the Department of Finance and Administration and the Bureau of TennCare that a managed care organization has, due to the start-up of TennCare, experienced financial difficulties; but appears to be a financially viable organization that is capable of providing contractually sound TennCare services. In these circumstances, a supplemental payment may be provided on a one-time basis. Such payment would be approved by the Commissioner of Finance and Administration;

5. Uncompensated care payments to essential hospital providers identified in (9)(d)1., computed according to the methodology set out below. Days will be calculated using the 1991 or earlier Hospital Cost Reports available as of June 1, 1992. Two mathematical models will be used for computing payments. In terms of payment composition, Model 1 has a value of 25% of the total annual amount, and Model 2 has a value of 75% of the total annual amount, subject to upper limits tests set out below.

   (i) *Uncompensated Care Payments (UCPs) - Model 1 [25%]*

   Payments to hospitals under this section will be made in the following manner:

   (I) Acute care hospitals having over 3,000 inpatient days attributable to patients determined eligible for Medicaid by the State of Tennessee or a utilization ratio of 14% or one standard deviation above the mean utilization ratio for all hospitals, whichever is lower, will be provided a payment incentive. The UCP shall not be subject to trending. The UCP will be the higher of I. or II. below but shall not exceed 34% and I. + III. or II. + III. shall not exceed 44%.

   I. The prospective rate will be adjusted upward by 6% for each 1% increment in the utilization rate above 14% or one standard deviation above the mean, whichever is lower.

   II. The prospective rate will be adjusted upward by 6% for each increment of 1,000 reimbursed inpatient reported Medicaid days over 3,000 and the prospective rate will be increased upward by 3% if total days exceed 3,650 but are less than 4,000.

   III. The prospective rate will be adjusted upward by 10% if outpatient services and outpatient pharmacy services are provided to Medicaid and/or non-Medicaid recipients who receive indigent services from the hospital. The hospital must qualify under I. or II. in order to receive this adjustment. Also, in order to receive adjustment III., the provider must be able to document that the services rendered qualify as free client care, under generally accepted accounting principles which are applicable to hospitals, and this does not include bad debt.

IV. No total payment of the uncompensated care payment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the 1989 Tennessee Hospital Joint Annual Report as submitted to the State Center of Health Statistics and validated as complete.

(II) Acute care hospitals that do not qualify under the criteria in (I) above but which have alow-income inpatient utilization rate exceeding 25% will receive the following payment incentive:

I. The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.

II. No total payment of the uncompensated care payment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the 1989 Tennessee Hospital Joint Annual report as submitted to the State Center of Health Statistics and validated as complete.

III. Low-income utilization rate will be calculated as follows from information obtained from the 1989 Tennessee Hospital Joint Annual Report as submitted to the State Center of Health Statistics and validated as complete. The sum of:

A. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

B. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State plan) that are reductions in charges given to other third party payers, such as HMO's, Medicare or Blue Cross.

(III) Any acute care hospital qualifying for an uncompensated care payment under the qualifying criteria listed in (I) and (II) above and having at least 1,000 projected FY 92/93 Medicaid days and having a Medicaid utilization ratio that exceeds the industry average utilization ratio which is computed by dividing the available hospital days into the Medicaid industry days will be eligible for an additional enhanced uncompensated care payment based on the following:

I. The prospective rate will be adjusted upward by an amount equal to the difference between the hospital's Medicaid utilization ratio and the industry average utilization ratio, multiplied by a factor of 9.45.

II. The enhanced UCP will be based on the enhanced UCP calculated in I. above, multiplied by the anticipated number of Medicaid days for FY 92/93.

III. The sum of the UCP payment calculated in (I), (II), and the enhanced payment computed in (III) cannot exceed the aggregate sum of inpatient and outpatient charity care and bad debt charges and Medicaid and Medicare contractual adjustments converted to cost based on the 1989 Tennessee Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

(ii) Uncompensated Care Payments (UCPs) - Model 2 [75%]

(I) A computation will be made of acute care hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a Medicaid utilization ratio over 7.94% or having a low income utilization ratio equal to or greater than 25%. The UCP will be the higher of I., II. or III. below, and cannot exceed 40% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this calculation, Medicaid days will not include days reimbursed by any HMO under contract with theState during this period. For the purposes of this calculation charity unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both instate and out-of-state services. For the purposes of computing the UCP, the UCP prospective rate will be considered to be the operating per diem for FY 1992/93, prior to the application of the trending factor, plus a capital per diem and a direct medical education per diem.

I The prospective rate will be adjusted upward by factor of 27.169 times the difference between the actual utilization rate if it exceeds 7.94% and 7.94% utilization rate.

II. The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.

III. The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate if it exceeds 25% and a 25% low income utilization rate. This adjustment will be capped at 10%.

IV. If the hospital does not qualify in I, II, or III above and their Medicare/Medicaid utilization rate exceeds 80%, then the number of percentage points by which the hospital's Medicare/Medicaid utilization rate exceeds 80% will be multiplied by 27.169. The product will then be multiplied by the hospital's per diem Medicaid payment and the total number of actual Medicaid days. The UCP cannot exceed 40% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost.

V. Low-income utilization rate will be calculated as follows from information obtained from the 1990 Tennessee Hospital Joint Annual

Report as submitted to the State Center of Health Statistics and validated as complete. The sum of:

A. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

B. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third-party payers such as HMO's, Medicare or Blue Cross.

VI. The uncompensated care payment will be calculated on a basis of anticipated number of Medicaid days for FY 92/93, except in (9)(b)5.(ii)(I)IV.

VII. The first upper limit test for the above uncompensated payment test is $430,500,000 on an annual basis. If the initial calculation exceeds this amount, then an allocation will be made based on percent to total.

VIII. Amounts as calculated in (b)5.(i)(III)III. and (b)5.(ii)(I)VII. for essential acute care hospitals as described in (9)(d)1. of this rule will then be summarized. If this amount exceeds $100,000,000 on an annual basis, then an allocation will be made based on percent to total; and

6. Payments to other providers for services provided to individuals eligible for TennCare but not enrolled.

(c) The priority of available funds to be disbursed from the UFP to provide for eligible payments as described in (b) above is as follows:

1. Medicaid education payments to certain essential providers identified in (9)(d)1.(i)-(v), if they previously received these payments under the Medicaid program;

2. Payments to essential providers identified in (9)(d)1.(i)-(v) and (9)(d)2. of this section for services provided to individuals eligible for TennCare but not enrolled;

3. Payments to the MCO for the first thirty (30) days of care for each enrollee in the MCO's uninsured population. This payment will be based on the actual adjudicated payment that the MCO has reimbursed providers for services. These payments would be in addition to the capitation rate;

(Rule 1200-13-12-.08, continued)

4. Payments to managed care organizations should it be determined by the Department of Finance and Administration and the Bureau of TennCare that a managed care organization has, due to the start-up of TennCare, experienced financial difficulties, but appears to be a financially viable organization that is capable of providing contractually sound TennCare services. In these circumstances, a supplemental payment may be provided on a one-time basis. Such payment would be approved by the Commissioner of Finance and Administration;

5. Uncompensated care payments to essential hospital providers as set out at (9)(b)5. of this rule;

6. Payments to other providers for services provided to individuals eligible for TennCare but not enrolled.

(d) To qualify as an essential provider, one of the following characteristics must be met:

1. Essential Acute Care Hospitals

(i) Major teaching hospitals with a Medicaid education cost of at least $2,500,000 per year or aminority operated teaching hospital.

(ii) Children's hospitals with at least 30% Medicaid inpatient hospital utilization.

(iii) Any state of Tennessee operated acute care hospital.

(iv) Large safety net hospitals, meaning any acute care hospital with at least 400 beds and a Medicaid utilization rate of 10% and located in one of the community health agency regions as follows:

(I) First Tennessee

(II) East Tennessee

(III) Southeast Tennessee

(IV) Upper Cumberland

(V) Mid-Cumberland

(VI) Northwest Tennessee

(VII) South Central Tennessee

(VIII) Southwest Tennessee

(v) Sole community hospitals (as designated by Medicare)

(vi) Any acute care hospital that has more than 60% of Medicare and/or Medicaid days as a percent of total patient days excluding nursery days. These percentages will be computed using the most recent cost report and revisions on file as of September 30 of the current year.

The qualifiers in items (i)-(iv) above will be based on the Comptroller's data base that was used for the state fiscal year 1993/94 hospital pass through computations for the State of Tennessee Medicaid Program.

2. Other essential providers shall be considered for purposes of payments under (9)(b)2. of this rule subject to the availability of funds:

(i) All state and local health department programs including community health agencies.

(ii) All community mental health centers.

(iii) All community mental retardation centers.

(iv) All state mental institutions

(v) All rural health clinics.

(vi) All federally qualified health centers.

(e) The maximum payment to providers will be calculated as follows:

1. Reimbursement for direct and indirect Medicaid education costs will be made based on the previous formula used to compute those costs, which is described in Rules 1200-13-5-.08 and 1200-13-5-.10 in effect on December 31, 1993. This amount will be capped at the new computation or the amount paid on an interim basis for state fiscal year (SFY) 1993, whichever is less.

2. Reimbursement for qualifying medical bills will be based on the amount that would have been paid by the MCO of the provider's choice for the service as if the service had been rendered to a TennCare enrollee. Reasonable efforts must be made to collect any amount due. Revenue collected by the provider must be used to reduce the amount paid by TennCare for qualifying medical bills.

3. Payments from this fund will not exceed a provider's TennCare uncompensated care costs.

(10) Effective with the implementation of TennCare, provisions will be made for reserve fund pool (RF) payments subject to the availability of funds and the ability of the state to provide adequate matching funds to generate Federal Financial Participation.

(a) Funding Availability of Reserve Fund Pool

A total of $30 million will be made available annually by the TennCare program for payments from the Reserve Fund Pool, subject to the availability of funds.

(b) The Reserve Fund Pool payments consist of two components. They are:

1. Primary Care Assistance Fund ($20 million annually)

This fund will be used to make payments to primary care providers whose TennCare caseload exceeds the average total TennCare patient caseload for all primary care providers. The pool is budgeted at $20 million annually. Payments for the period of January through June 1994 will not exceed $10 million.

(i) Primary care providers, for purposes of this rule, are defined as follows:

(I) Primary care physicians

I. Physicians who have limited their practice of medicine to general practice, or

II. Physicians who are Board Certified or Board Eligible in any of the following: Internal Medicine, Pediatrics, Obstetrics/Gynecology, or Family Practice.

(II) Advanced Practice Nurses, Nurse Practitioners, and Physician Assistants engaged in the delivery of primary care

(III) Community Health Clinics (each clinic counts as a single provider)

(IV) Federally Qualified Health Centers (each center counts as a single provider)

(ii) Methodology for calculating payments to primary care providers

(I) Using data extracted from the encounter data submitted by the MCOs, a determination will be made of each participating primary care provider's total TennCare caseload.

(II) Using data extracted from the encounter data submitted by the MCOs, a calculation will be made of the average total TennCare patient caseload of all primary care providers.

(III) A list will then be compiled of primary care providers whose TennCare caseload exceeds the average. These providers will be termed qualifying providers, for purposes of the Reserve Fund Pool.

(IV) The number of TennCare enrollees for each qualifying provider that exceeds the average in (ii)(II) above will be summarized for all qualifiers. This sum will be divided into $20,000,000 to get a value for each TennCare enrollee.

(V) The value derived in (ii)(IV) above will be multiplied by each qualifying provider's number of enrollees above the average in order to determine the payment to be made to that provider from the Reserve Fund Pool. The minimum payment to qualifying providers will be $1,000 and the maximum payment will be $30,000.

(VI) Total payments from the Primary Care Assistance Fund will not exceed $20,000,000. If the total of the payments calculated in (ii)(V) above exceeds $20,000,000, an allocation of the overage will be made based upon each provider's share before reduction of the overage.

(VII) The payment will be made on an annual basis after the end of the State's fiscal year.

2. Malpractice Assistance Fund ($10 million annually)

This fund will be used to assist physicians who serve TennCare patients with the cost of their malpractice insurance related to TennCare. The pool is budgeted at $10 million annually. Payments for the period of January through June 1994 will not exceed $5 million.

(Rule 1200-13-12-.08, continued)

The methodology is as follows:

(i) Any physician whose practice is made up of 10% or more TennCare patients on an annual basis will be eligible for assistance with payment of his/her malpractice premiums.

(ii) Using encounter data submitted by the MCOs and surveys of physician practices, the percentage of each qualifying physician's practice which is TennCare will be determined on an annual basis.

(iii) Using information from SVMIC as a standard, the amount of each qualifying physician's malpractice premium will be verified.

(iv) The percentage developed in (ii) above will be multiplied by the premium amount determined in (iii) above to arrive at the maximum payment to be made to each qualifying physician. Should the total maximum payments for all qualifying physicians exceed $10 million, these payments will be adjusted down on a prorata basis.

(v) This payment will be made on an annual basis after the end of the State's fiscal year

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Public Chapter 358 of the "Acts of 1993".* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed February 16, 1995; effective May 2, 1995. Amendment filed March 3, 1995; effective May 17, 1995.*

1200-13-12-.09 THIRD PARTY RESOURCES.

(1) Individuals applying for TennCare coverage shall disclose the availability of any third party health care coverage to the agency responsible for determining the individual's eligibility for TennCare.

(2) Individuals enrolled in TennCare shall disclose access to third party resources to their specified Managed Care Organizations as soon as they become aware of the existence of any third party resources.

(3) Managed Care Organizations under contract with the Tennessee Departments of Finance and Administration or Mental Health and Developmental Disabilities shall provide all third party resource information obtained from their enrollees to the Bureau of TennCare on a regular basis as required by their contracts.

(4) Managed Care Organizations shall enforce TennCare subrogation rights pursuant to T.C.A. § 71-5-117.

(5) Managed Care Organizations may pay health insurance premiums for their enrollees if such payments are determined to be cost effective.

(6) TennCare shall be the payor of last resort, except where contrary to federal or state law.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, Public Chapter 358 of the "Acts of 1993", and Executive Order No. of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed July 6, 2001; effective September 19, 2001.*

1200-13-12-.10 EXCLUSIONS. Managed care organizations are not obligated to pay for non-covered services or for non-emergency services obtained outside the health plan. Non-covered services include, but are not limited to, the following:

(1) Services which are not medically necessary, except that preventive and EPSDT services shall be covered;

(2) Eyeglasses, hearing aids or non-emergency dental services for adults;

(3) Services performed for cosmetic purposes;

(4) Medical services for individuals committed to penal institutions, whether local, state or federal;

(5) Medical services performed outside the United States;

(6) Except as further described in this rule, organ transplants or other medical procedures which are considered experimental or investigational, including the performance of a specified medical procedure which would be covered except for the fact that it is used in a manner that is not a recognized mode of treatment for a specific medical condition. The following organ transplants or other medical procedures shall be deemed to be covered services when the conditions described herein are met:

(a) Dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer. Coverage shall be limited to treatments administered according to National Cancer Institute (NCI) approved protocols in centers that are NCI approved or, if a center is not NCI approved, a center that meets the NCI established standards (e.g., record-keeping, informed consent, follow-up, etc.). A non-NCI approved center is responsible for providing evidence to the managed care organization that it meets NCI established standards. It shall be the responsibility of the managed care organization to determine compliance with the NCI standards for non-NCI approved centers and to contract with appropriate NCI approved and NCI equivalent centers within 90 days of the effective date of this rule. All benefits, including but not limited to physician services, hospital inpatient or outpatient services, laboratory services, radiological services, pharmacy services, etc. that would otherwise be available to the enrollee shall also be available when the services are required as a component of, or adjunctive to, the provision of dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer.

(7) Weight reduction programs; intestinal by-pass surgery (unless medically necessary), or gastric stapling (unless medically necessary);

(8) Services for the treatment of impotence or infertility or for the reversal of sterilization;

(9) Autopsy/Necropsy;

(10) Job-related illness or injury covered by workers compensation;

(11) Pre-employment physical examinations; and

(12) Fitness to duty examinations.

(13) Non-covered investigative treatment or procedures include, but are not limited to, the following:

(a) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(b) If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, medical treatment or procedure, was not reviewed and approved

by the treating facility's Institutional Review Board or other body serving a similar function, if federal law requires such review and approval; or

(c) If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials; is being used in the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(d) If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Authority: *T.C.A. §§4-4-102, 4-5-202, 71-5-105, 71-5-107, 71-5-109, 71-5-10, Executive Order No. 1 of 1995, Title 42, Part 441 of the Code of Federal Regulations, and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Amendment filed September 30, 1996; effective December 14, 1996. Amendment filed February 23, 2001; effective May 9, 2001.*

1200-13-12-.11 APPEAL OF ADVERSE ACTIONS AFFECTING TENNCARE SERVICES OR BENEFITS

(1) Definitions. For the purpose of this rule, the following definitions apply:

(a) Administrative Hearing - a contested case proceeding held pursuant to the provisions of the Tennessee Uniform Administrative Procedures Act, Tennessee Code Annotated §§ 4-5-301, et seq., except as noted otherwise herein, to allow an enrollee to appeal an adverse decision of the TennCare Program. An evidentiary hearing is held before an impartial hearing officer who renders an initial order under Tennessee Code Annotated § 4-5-314. If an enrollee appeals the initial order under Tennessee Code Annotated § 4-5-315, the Commissioner may render a final order.

(b) Adverse Action Affecting TennCare Services or Benefits - includes, but is not limited to, delay, denial, reduction, suspension or termination of TennCare benefits, as well as any other act or omission of the TennCare Program which impairs the quality, timeliness, or availability of such benefits.

(c) Commissioner - the chief administrative officer of the Tennessee Department where the TennCare Bureau is administratively located, or the Commissioner's designee.

(d) Continuation or Reinstatement of Services - the following services or benefits are subject to continuation or reinstatement pursuant to paragraph (5)(g) of this rule:

1. Those services currently or most recently provided to an enrollee; or

2. Those services being provided to an enrollee in an inpatient psychiatric facility or residential treatment facility where the discharge plan has not been accepted by the enrollee or appropriate step-down services are not available; or

3. Those services being provided to treat an enrollee's chronic condition across a continuum of services when the next appropriate level of covered services is not available; or

4. Those services prescribed by the enrollee's provider on an open-ended basis or with no specific ending date where the MCC has not reissued prior authorization; or

(Rule 1200-13-12-.11, continued)

5. A different level of covered services, offered by the MCC and accepted by the enrollee, for the same illness or medical condition for which the disputed service has previously been provided.

(e) Covered Services - the services and benefits that:

1. TennCare MCOs or BHOs cover, as set out in section 1200-13-12-.04 of the rules of the Bureau of TennCare; or

2. In the instance of enrollees who are eligible for and enrolled in federal Medicaid waivers under Section 1315 of the Social Security Act, the services and benefits that are covered under the terms and conditions of such waivers.

(f) Decision in Favor of an Enrollee - Refers, in the case of a decision by an impartial hearing officer, to the initial decision on the merits of the appeal, and shall be treated as binding for purposes of this rule.

(g) Delay - includes, but is not limited to:

1. Any failure to provide timely receipt of TennCare services, and no specific waiting period may be required before the enrollee can appeal;

2. An MCC's failure to provide timely prior authorization of a TennCare service. In no event shall a prior authorization decision be deemed timely unless it is granted within twenty-one (21) calendar days of a request for such authorization, and a shorter period is required if a more prompt response is medically necessary in light of the enrollee's condition and the urgency of his need, as defined by a prudent lay person.

(h) Enrollee - as used in this rule, an individual eligible for and enrolled in the TennCare program or in any Tennessee federal Medicaid waiver program approved by the Secretary of the U.S. Department of Health and Human Services pursuant to Sections 1115 or 1915 of the Social Security Act. As concerns MCC compliance with this rule, the term only applies to those individuals for whom the MCC has received at least one day's prior written or electronic notice from the TennCare Bureau of the individual's assignment to the MCC.

(i) Impartial Hearing Officer - as used in this rule, an Administrative Judge or Hearing Officer who is not an employee, agent or representative of the MCC and who did not participate in, nor was consulted about, any TennCare Bureau review prior to the Administrative Hearing.

(j) MCC - as used in this rule:

1. A managed care contractor (managed care organization (MCO) or behavioral health organization (BHO)) which has signed a TennCare Contractor's agreement with the State of Tennessee and which operates provider networks.

2. A pharmacy benefits manager (PBM), or dental benefits manager which subcontracts with such MCO or BHO; or

3. A state government agency (i.e., Department of Childrens Services and Division of Mental Retardation Services) which contracts with TennCare for the provision of services.

(k) Medical Assistance - health care, services and supplies furnished to an enrollee and funded in whole or in part under Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. and Tenn. Code Ann. § 71-5-101, et seq. Medical assistance includes the payment of the cost of

care, services, drugs and supplies. Such care, services, drugs, and supplies shall include services of qualified providers who have contracted with an MCC or are otherwise authorized to provide services to TennCare enrollees (i.e., emergency services provided out-of-network or medically necessary services obtained out-of-network because of an MCC's failure to provide adequate access to services in-network.

(l) Medically Contraindicated - as used in this rule, a TennCare benefit or service which it is necessary to withhold in order to safeguard the health or safety of the enrollee.

(m) Provider - a health care provider eligible by professional qualifications to participate in the TennCare Program and who is acting within his scope of practice.

(n) Provider-Initiated Reduction, Termination or Suspension of Services - as used in this rule, a decision to reduce, terminate, or suspend an enrollee's TennCare services which is initiated by the enrollee's provider, rather than instigated by the MCC.

(o) Provider with Prescribing Authority - in the context of TennCare pharmacy services, a health care professional authorized by law or regulation to order prescription medications for her patients, and who:

1. Participates in the provider network of the MCC in which the enrollee is enrolled; or

2. Has received a referral of the enrollee, approved by the MCC, authorizing her to treat the enrollee; or

3. In the case of a TennCare enrollee who is also enrolled in Medicare, is authorized to treat Medicare patients.

(p) Prudent Lay Person - a reasonable individual who possess an average knowledge of health and medicine.

(q) Readable - no more than a sixth grade level of reading proficiency is needed to understand notices or other written communications, as measured by the Fogg index, the Flesch Index, the Flesch-Kincaid Index, or other recognized readability instrument. The preprinted language approved by the U.S. District Court following entry of the Grier v. Wadley Revised Consent Decree and distributed to MCCs as templates is readable. It is the responsibility of the entity issuing the notice to ensure that text added to the template is readable, with the exception of medical, clinical or legal terminology.

(r) Receipt of Mailed Notice - Receipt of any notice contemplated by this rule, unless otherwise specified in the rule, shall be presumed to be within five (5) calendar days of the date of mailing.

(s) Reconsideration - the process by which an MCC reviews and renders a decision regarding an enrollee's appeal of the MCC's adverse action affecting TennCare benefits.

(t) Reduction, Suspension or Termination - acts or omissions by TennCare or others acting on its behalf which result in the interruption of a course of necessary clinical treatment for a continuing spell of illness or medical condition, as MCCs are responsible for the management and provision of medically necessary covered services throughout an enrollee's illness or need for such services, and across the continuum of covered services, including, but not limited to behavioral health services and appropriate transition plans specified in the applicable TennCare contract. The fact that an enrollee's medical condition requires a change in the site or type of TennCare service does not lessen the MCC's obligation to provide covered treatment on a continuous and ongoing basis as medically necessary.

(u) TennCare Appeal Form - the TennCare form(s) which are completed by an enrollee, or by a person authorized by the enrollee to do so, whenever an enrollee appeals an adverse action affecting TennCare services. The use of the form is not required, but is encouraged to ensure the MCC and TennCare Bureau have the necessary information.

(v) TennCare Benefits or TennCare Services - any medical assistance that is administered by the Bureau of TennCare or its contractors and which is funded wholly or in part with federal funds under the Medicaid Act or any waiver thereof, but excluding:

1. Medical assistance that can be appealed through an appeal of a pre-admission evaluation (PAE) determination; and

2. Medicare cost sharing services that do not involve utilization review by the Bureau of TennCare or its contractors.

(w) TennCare Bureau ("TennCare") - the administrative unit of the state Department which is responsible for the administration of the TennCare Program.

(x) TennCare Program - the joint federal/state medical assistance program administered pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396, et seq. (hereinafter "Medicaid Act"), including Tennessee' Medicaid Demonstration Project Number 11-C-99638/4-03 called "TennCare."

(y) Time - Sensitive Care - care which requires a prompt medical response in light of the enrollee's condition and the urgency of her need as defined by a prudent lay person; provided, however, that a case may be treated as non-time-sensitive upon the written certification of the enrollee's treating physician.

(z) Treating Physician (or Clinician) - a health care provider who has provided diagnostic or treatment services for an enrollee (whether or not those services were covered by TennCare), for purposes of treating, or supporting the treatment of, a known or suspected medical condition. The term excludes providers who have evaluated an enrollee's medical condition primarily or exclusively for the purposes of supporting or participating in a decision regarding TennCare coverage.

(2) Notice Requirements

(a) When Written Notice is Required

1. A written notice shall be given to an enrollee by his/her MCC of any adverse action taken by the MCC to deny, reduce, suspend, or terminate medical assistance.

2. A written notice shall be given to an enrollee whenever his/her MCC has reason to expect that covered medical assistance for the enrollee will be delayed beyond the time lines prescribed by the TennCare contract or the terms and conditions of the TennCare waiver. Actions which can reasonably be anticipated to delay or disrupt access to medical assistance include:

(i) Change of primary care provider;

(ii) Pharmacy "lock-in";

(iii) Decisions affecting the designation of a person as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED);

(iv) Termination of a provider's contract, by either party to the contract; or

(v) Inability to provide an adequate provider network.

3. A written notice shall be given to an enrollee when he/she has been prescribed a covered service on an on-going basis or with no specific ending date and the service is subject to a prior authorization requirement.

4. A written notice shall be given to an enrollee of any MCC-initiated reduction, termination or suspension of inpatient hospital care.

5. A written notice shall be given to an enrollee of any provider-initiated reduction, termination or suspension of:

(i) Any behavioral health service for a severely and persistently mentally ill (SPMI) adult enrollee or severely emotionally disturbed (SED) child;

(ii) Any inpatient psychiatric or residential service;

(iii) Any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available; or

(iv) Home health services.

The enrollee's MCC shall be promptly notified of a provider's proposal to reduce, terminate or suspend one of the above services and of the recommended discharge plan, if any, to insure compliance with this rule.

(b) Timing of Written Notice

1. Written notice of MCC-initiated reduction, termination or suspension of medical assistance must be provided to an enrollee within the time frames required by 42 C.F.R. §§431.210-.214 (usually ten (10) days in advance). However, in instances of MCC-initiated reduction, termination or suspension of inpatient hospital treatment, the notice must be provided to an enrollee at least two business days in advance of the proposed action. Where applicable and not in conflict with this rule, the exceptions set out at 42 C.F.R. § 431.211-.214 permit or require reduction of the time frames within which advance notice must be provided.

2. Written notice of an MCC's decision in response to a request by or on behalf of an enrollee for medical or related services must be provided within twenty-one (21) calendar days of receipt of the request; however, a shorter period is required if a more prompt response is medically necessary in light of the enrollee's condition and the urgency of his/her need, as defined by a prudent lay person.

3. Written notice of delay of covered medical assistance must be provided to an enrollee immediately upon an MCC's receipt of information leading it to expect that such delay will occur.

4. Written notice of expiration of a prior authorization for a covered service which has been prescribed on an on-going basis or with no specific ending date must be provided to an enrollee no more than forty (40) days, nor less than thirty (30) days, prior to the

expiration of the prior authorization. However, in the event that the period of authorization is less than thirty (30) days, the notice shall be issued upon authorization.

5. Where required by paragraph (2)(a)5. of this rule, written notice of provider-initiated reduction, termination or suspension of services must be provided to an enrollee at least two (2) business days in advance of the proposed action.

6. Written notice is deemed to be provided to an enrollee upon deposit with the U.S. Postal Service or other commercial mail carrier, or upon hand-delivery to an enrollee or his/her representative.

(c) Notice Contents

1. Whenever this rule requires that a TennCare enrollee receive written notice of an adverse action affecting medical assistance, the notice must contain the following elements, written in concise, readable terms:

(i) The type and amount of TennCare services at issue and the identity of the individual, if any, who prescribed the services.

(ii) A statement of reasons for the proposed action. The statement of reasons shall include the specific facts, personal to the enrollee, which support the proposed action and sources from which such facts are derived. If the proposed action turns on a determination of medical necessity or other clinical decision, the statement of reasons shall:

(I) Identify by name those clinicians who were consulted in reaching the decision at issue;

(II) Identify specifically those medical records upon which those clinicians relied in reaching their decision; and

(III) Specify what part(s) of the criteria for medical necessity or coverage was not met.

(iii) Reference to the legal or policy basis for a proposed adverse action, including a plain and concise statement of, and official citation to, the applicable law, federal waiver provision, or TennCare contract provision relied upon.

(iv) Inform the enrollee about the opportunity to contest the decision, including the right to an expedited appeal in the case of urgent care and, in the case of termination, reduction or suspension of on-going services, the right to continuation of services pending appeal; and

(v) If the enrollee has an ongoing illness or condition requiring medical care and the MCC or its network provider is under a duty to provide a discharge plan or otherwise arrange for the continuation of treatment following the proposed adverse action, the notice must include a readable explanation of the discharge plan, if any, and a description of the specific arrangements in place to provide for the enrollee's continuing care.

2. Binding Effect of Original Notice. TennCare and the MCCs shall be bound by their own notices, and may not rely upon any reasons or legal authorities other than those which they include in their written notices to a TennCare enrollee. Therefore, in the event that an enrollee appeals an adverse action, the reviewing authority shall consider only the

factual reasons and legal authorities cited in the original notice to the enrollee, except that additional evidence beneficial to the enrollee may be considered on appeal.

3. Insufficient Legal Authority in Notice. TennCare and the MCCs may not cite or rely upon policies that are inconsistent with federal law, the TennCare waiver, properly promulgated rules or contract provisions. If the MCC's reasons or legal authorities are not sufficient to support the proposed adverse action, the proposed action must be overruled and the disputed service must be provided. While this does not preclude the issuance of a new notice that may provide the predicate for subsequent adverse action, the new notice shall not cure the deficiencies in the original notice.

(d) Special Provisions Pertaining to Pharmacy Notice.

1. If the service at issue is a prescription drug, and the enrollee does not receive the medication of the type and amount prescribed, a written notice shall be provided by the pharmacy to inform the enrollee of:

(i) The circumstances under which the enrollee may obtain a two week supply of the prescribed medicine and how to do so;

(ii) The enrollee's right to appeal the denial or termination of the medication and how to do so; and

(iii) The right to request continuation of services pending appeal.

2. In the event that the enrollee appeals a denial or termination of a pharmacy benefit and the appeal is not resolved to the enrollee's satisfaction within ten (10) days from the date of receipt of the appeal, the MCC shall issue a notice containing the information described in paragraph (2)(c) above.

(e) Notice of Rights. The Bureau of TennCare shall provide annual notice to TennCare enrollees of their notice and appeal rights established by this rule, including enrollees' recourse when billed by a provider for TennCare covered services. Additionally, upon enrollment in an MCC, the MCC shall give the enrollee a plain language explanation of appeal rights.

(f) Proper use of the approved template notices designated by the Grier v. Wadley Revised Consent Decree shall be deemed to satisfy the notice requirements specified by this rule.

(g) Violation of Notice Requirements and Corrective Action

1. No adverse action affecting TennCare services shall be effective unless the notice requirements of the federal regulations (42 C.F.R. § 431.210-.214), as enhanced or otherwise modified herein, have been complied with. TennCare shall not withhold, or permit others acting on its behalf to withhold, any TennCare services in violation of this requirement.

2. Whenever it comes to the attention of the Bureau of TennCare or an MCC that a TennCare covered service will be or has been delayed, denied, reduced, suspended or terminated in violation of any of the notice requirements of this rule, TennCare or the MCC will immediately provide that service in the quantity and for the duration prescribed, subject to TennCare's or the MCC's right to reduce or terminate the service in accordance with the procedures required by this rule.

(Rule 1200-13-12-.11, continued)

3. In the event that the enrollee lacks a prescription for the covered TennCare service which has been delayed, denied, reduced, suspended or terminated in violation of notice requirements, the following shall occur:

(i) The enrollee will be immediately afforded access, at the earliest time practicable, to a qualified provider to determine whether the service should be prescribed;

(ii) The provider will be informed that the service will be authorized if prescribed; and

(iii) Entitlement to the service will not be controlled by the MCC's utilization review process.

4. In the event that the notice violation has occurred with regard to a delay of access to a physician to secure the requested medical assistance, such access shall be provided as soon as practicable. The enrollee shall be entitled to continue to receive such service until such time as the MCC takes those actions required by federal regulations and this rule as a prerequisite to taking any adverse action affecting TennCare services.

(3) Appeal Rights of Enrollees. Enrollees have the following rights:

(a) To appeal adverse actions affecting TennCare services.

(b) To have oral or written expressions by the enrollee, or on his behalf, of dissatisfaction or disagreement with adverse actions that have been taken or are proposed to be taken, treated as appeals, including instances in which:

1. The enrollee lacks an order or prescription from a provider supporting the appeal;

2. TennCare or an MCC has agreed to cover a prescribed service in an amount that is less than the amount or duration sought by the enrollee;

3. TennCare or an MCC has agreed to provide a covered service that is different from that sought by the enrollee;

4. An enrollee seeks to contest a delay or denial of care resulting from the MCC's failure or refusal to make a needed service available, due to the inadequacy of the MCC's provider network;

5. An enrollee seeks to contest a denial of his right under the TennCare waiver to choose his own primary care provider (PCP) from among a panel offered by the MCC, or seeks to contest a delay or denial of care resulting from the involuntary assignment of a PCP;

6. An enrollee seeks to contest or change his assignment to a particular MCO or BHO;

7. An enrollee seeks to contest denial of TennCare coverage for services already received, regardless of the cost or value of the services at issue; and

8. An enrollee seeks to contest a decision granting or withholding designation as severely and persistently mentally ill (SPMI) or severely emotionally disturbed (SED).

(c) Have the appeal rights that are prescribed by 42 C.F.R. Part 431, Subpart E and Tennessee Code Annotated §§ 4-5-301, et seq.

(Rule 1200-13-12-.11, continued)

(d) Be allowed thirty (30) days from receipt of written notice or, if no notice is provided, from the time the enrollee becomes aware of an adverse action, to appeal any adverse action affecting TennCare services.

(e) To appeal in person, by telephone or in writing. Reasonable accommodations shall be made for persons with disabilities who require assistance with their appeal, such as an appeal by TDD services or other communication device for people with disabilities. Written requests for appeals made at county Department of Human Services or Health Department offices shall be stamped, and immediately forwarded to the TennCare Bureau for processing and entry in the central registry;

(f) To file an appeal through a toll-free phone number on a twenty-four (24) hours a day, seven (7) days a week basis. Resolution of appeals outside of regular business hours will be available only in cases of emergency medical condition.

(g) For ongoing services, have the right to continuation or reinstatement of services, pursuant to 42 C.F.R. §§ 431.230-.231 as adapted by this rule, pending appeal when they submit a timely appeal and request for such services. When an enrollee is so entitled to continuation or reinstatement of services, this right may not be denied for any reason, including:

1. An MCC's failure to inform an enrollee of the availability of such continued services;

2. An MCC's failure to reimburse providers for delivering services pending appeal; or

3. An MCC's failure to provide such services when timely requested.

(h) The right to an impartial appeals process. But for initial reconsideration by an MCC as permitted by this rule, no person who is an employee, agent or representative of an MCC may participate in deciding the outcome of a TennCare appeal. No state official may participate in deciding the outcome of an enrollee's appeal who was directly involved in the initial determination of the action in question.

(4) Special Provisions Relating to Appeals

(a) Individualized Decisions Required. Neither the TennCare program nor its MCCs may employ utilization control guidelines or other quantitative coverage limits, whether explicit or de facto, unless supported by an individualized determination of medical necessity based upon the needs of each TennCare enrollee and his or her medical history.

(b) Decisions to be Supported by Substantial and Material Evidence. Throughout all stages of an appeal of an adverse action affecting TennCare services, decisions shall be based upon substantial and material evidence. In cases involving clinical judgments, this requirement means that:

1. Appeal decision must be supported by medical evidence, and it is the MCCs' and TennCare's responsibility to elicit from enrollees and their treating providers all pertinent medical records that support an appeal; and

2. The decisions or opinions of an enrollee's treating physician or other prescribing clinician shall not be overruled by either the MCC initially or TennCare upon review, unless there is substantial and material medical evidence, documented in the enrollee's medical records, to justify such action. Reliance upon insurance industry guidelines or utilization control criteria of general application, without consideration of the individual enrollee's medical history, does not satisfy this requirement and cannot be relied upon to support an adverse action affecting TennCare services.

(c) Record on Review. When TennCare receives an appeal from an enrollee regarding an adverse action affecting TennCare services, TennCare is responsible for obtaining from the MCC any and all records or documents pertaining to the MCC's decision to take the contested action. TennCare shall correct any violation of this rule that is evident from a review of those records.

(5) Hearing Rights of Enrollees

(a) TennCare shall inform enrollees that they have the right to an in-person hearing, a telephone hearing or other hearing accommodation as may be required for enrollees with disabilities;

(b) Enrollees shall be entitled to a hearing before an impartial hearing officer that affords enrollees the right to:

1. Representation at the hearing by anyone of their choice, including a lawyer;

2. Review information and facts relied on for the decisions by the MCC and the TennCare Bureau before the hearing;

3. Cross-examine adverse witnesses;

4. Present evidence, including the right to compel attendance of witnesses at hearings;

5. Review and present information from their medical records;

6. Present evidence at the hearing challenging the adverse decision by his/her MCC;

7. Ask for an independent medical opinion, at no expense to the enrollee;

8. Continue or reinstate ongoing services pending a hearing decision, as specified in this rule;

9. A written decision setting out the impartial hearing officer's rulings on findings of fact and conclusions of law; and

10. An initial hearing decision (initial order) by the impartial hearing officer within ninety (90) days, or thirty-one (31) days in the case of a time-sensitive appeal, of the date of receipt of the appeal.

(c) TennCare shall not impair the ability of an enrollee to appeal an adverse hearing decision by requiring that the enrollee bear the expense of purchasing a hearing transcript when such purchase would be a financial hardship for the enrollee.

(d) Parties to an Appeal. Under this rule, the parties to an administrative hearing are limited to those permitted by federal regulations. The purpose of the hearing is to focus on the enrollee's medical needs. MCCs are not permitted to intervene or participate as parties in an enrollee's hearing. However, MCC employees may participate as witnesses in hearings. Further, nothing in this provision bars participation by an MCC in any informal resolution phase of the appeal process prior to a hearing before the impartial hearing officer.

(e) Consistent with the Code of Judicial Conduct, impartial hearing officers shall assist pro se enrollees in developing the factual record; they shall have authority to order second medical opinions at no expense to the enrollee.

(f) Review of Hearing Decisions/Binding Effect of Decisions in Favor of Enrollees.

1. Review of impartial hearing officers' decisions shall be available to enrollees pursuant to the Tennessee Administrative Procedures Act, Tennessee Code Annotated §§ 4-5-301, et seq.

2. If the enrollee prevails at any stage of the appeal process, the decision is binding upon TennCare and the MCC. If the enrollee prevails by decision of an impartial hearing officer, the services shall be provided, and neither TennCare nor the MCC shall appeal.

3. An impartial hearing officer's decision in an enrollee's appeal shall not be deemed precedent for future appeals. To seek relief from the decision, TennCare may apply to federal court or enact rules and regulations, including emergency or public necessity rules, in accordance with the state Administrative Procedures Act.

(g) Continuation or Reinstatement of TennCare Services

1. Except as permitted under 42 C.F.R. §§ 431.213, 431.214 and 431.220, as modified by this rule, TennCare services shall continue (or be reinstated) until an initial hearing decision if the enrollee appeals and requests:

(i) Continuation of services within two (2) business days of the receipt of MCC-initiated notice of action to terminate, suspend or reduce ongoing inpatient hospital treatment,

(ii) Continuation of services within two (2) business days of the receipt of provider-initiated notice of action to terminate, suspend or reduce any behavioral health service for a severely and persistently mentally ill (SPMI) adult enrollee or severely emotionally disturbed (SED) child, any inpatient psychiatric or residential service, any service being provided to treat a patient's chronic condition across a continuum of services when the next appropriate level of medical service is not immediately available, or home health services; or

(iii) Continuation of services within ten (10) days of the receipt of MCC-initiated notice of action to terminate, suspend or reduce other ongoing services; or

(iv) Reinstatement of the services described in paragraph (5)(g)1.(i) - (iii) above within thirty (30) days of the receipt of the notice of action.

2. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (5)(g)1.(ii) above, the enrollee shall be afforded access to a written second medical opinion from a qualified provider who participates in the MCC's network. If there has not already been a break in receipt of the services, the benefits shall continue until receipt of the written second medical opinion. Services shall continue (or be reinstated) thereafter pending appeal only if and to the extent prescribed by the second provider.

3. In the case of a timely request for continuation or reinstatement of the TennCare services described in paragraph (5)(g)1.(i) and (iii) above, the services shall continue (or be reinstated) pending appeal only if and to the extent prescribed by the enrollee's treating clinician.

4. Services shall not continue, but may be immediately reduced, terminated, or suspended if they are determined medically contraindicated in accordance with the provisions of paragraph (9) below.

5. Appeals involving continuation of ongoing services determined by TennCare as not medically necessary shall be handled as expedited appeals. Expedited appeals must be concluded within thirty-one (31) days, and such time frame may not be delayed except as ordered by the impartial hearing officer. Therefore, if an enrollee makes a timely request for continuation or reinstatement of a disputed TennCare service pending appeal, receives the continued or reinstated service, and subsequently requests a continuance of the proceedings without presenting a compelling justification, the impartial hearing officer shall grant the request for continuance conditionally. The condition of such continuance is the enrollee's waiver of his right to continue receiving the disputed services pending a decision if:

(i) The impartial hearing officer finds that such continuance is not necessitated by acts or omissions on the part of the State or MCC;

(ii) The enrollee lacks a compelling justification for the requested delay; and

(iii) The enrollee received at least three (3) weeks notice of the hearing, in the case of a standard appeal, or at least one (1) week's notice, in the case of an expedited appeal.

(h) Expedited appeal. Expedited appeal of any action involving time-sensitive care must be available to enrollees as follows:

1. The enrollee, the enrollee's parent, legal guardian or representative, or the enrollee's primary care provider or treating specialist asserts that the care in question requires a prompt medical response in light of the enrollee's condition and the urgency of the enrollee's needs as defined by a prudent lay person.

2. Care is not time-sensitive, and an appeal is not expedited, if the enrollee's treating physician certifies in writing that the matter is not time-sensitive.

3. An expedited appeal shall be resolved by hearing and a written hearing decision (initial order) within thirty-one (31) days from the date the appeal is received.

(6) Special Provisions Pertaining to Pharmacy

(a) When a provider with prescribing authority prescribes a medication for an enrollee, and the prescription is presented at a pharmacy that participates in the enrollee's MCC, the enrollee is entitled to:

1. The drug as prescribed, if the drug is on the MCC's formulary and does not require prior authorization; or

2. The drug as prescribed, if the prescribing provider has obtained prior authorization or established the medical necessity of the medication; or

3. An alternative medication, if the pharmacist consults the prescribing provider when the enrollee presents the prescription to be filled, and the provider prescribes a substituted drug; or

4. A two (2) week supply of the prescribed drug, if the pharmacist is unable when the enrollee presents the prescription to be filled, to obtain MCC authorization to substitute an alternative medication. If the enrollee does not receive the medication of the type and amount prescribed, TennCare or the MCC shall immediately provide written notice of the right to appeal, including the right to request continuation of services pending appeal.

The enrollee's entitlement to receive a two (2) week supply of the prescribed drug is subject to the provisions of paragraph (6)(b) below.

(b) The enrollee is entitled to a two (2) week supply of the prescribed drug, as mandated by the preceding paragraph, provided that:

1. The medication is not classified by the FDA as less than effective (i.e. a DESI, LTE or IRS drug); or

2. The medication is not a drug in a non-covered TennCare therapeutic category (e.g., appetite suppressants, drugs to treat infertility); or

3. Use of the medication has not been determined to be medically contraindicated because of the patient's medical condition or possible adverse drug interaction; or

4. If the prescription is for a total quantity less than a two (2) week supply, the pharmacist must provide a supply up to the amount prescribed.

(c) In some circumstances, it is not feasible for the pharmacist to dispense a two (2) week supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging. Examples would include, but not be limited to, inhalers, eye drops, ear drops, injections, topicals (creams, ointments, sprays), drugs packaged in special dispensers (birth control pills, steroid dose packs), and drugs that require reconstitution before dispensing (antibiotic powder for oral suspension). When coverage of a two (2) week supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense a two (2) week supply, it is the responsibility of the MCC to provide coverage for either the two (2) week supply or the usual dispensing amount, whichever is greater.

(d) If the enrollee does not receive the medication of the type and amount prescribed, written notice must be issued by the pharmacy, in accordance with paragraph (2)(d) above.

(7) Release of Enrollees' Medical Records

(a) When a request is made, by or on behalf of a TennCare enrollee, for approval of a TennCare service or for an appeal of an adverse action affecting TennCare services, the enrollee is deemed to have consented to release of his/her relevant medical records to his/her MCC and the TennCare Bureau for the purposes of acting upon the enrollee's request.

(b) Providers shall promptly provide copies of an enrollee's medical records to the enrollee's MCC(s) and to the TennCare Bureau upon being informed by the MCC(s) or TennCare Bureau that the records have been requested for the purpose of acting upon an enrollee's request for approval of a TennCare service or an enrollee's appeal of an adverse action affecting TennCare services.

(c) An enrollee's consent to release of his/her medical records may be evidenced by his signature (or his provider's or authorized representative's signature) upon the enrollee's initial application for TennCare, upon his TennCare appeal form or other written request for authorization or appeal, or, in the event of an appeal by telephone, by a TennCare Bureau employee's signing of an appeal form on behalf of an enrollee with documentation of consent to do so.

(d) The medical records obtained by MCCs and the TennCare Bureau under this rule remain confidential. MCCs and the TennCare Bureau may use and disclose the records only as necessary in their consideration of the enrollee's request for approval of a TennCare service or the enrollee's appeal of an adverse action affecting TennCare services.

(8) Time Requirements and Corrective Action

(a) Subject to the provisions of subparagraphs (8)(e) and (f) below and to provisions relating to medical contraindication (paragraph (9)), the failure of an MCC to act upon a request for prior approval within twenty-one (21) days shall result in automatic authorization of the requested service.

(b) The failure of an MCC to complete reconsideration of enrollee appeals within fourteen (14) days of notification by TennCare, in the case of a standard appeal, or within five (5) days in the case of expedited appeals involving time-sensitive care, shall result in immediate resolution of the appeal in favor of the enrollee, without further consideration or proceedings, subject to the provisions of subparagraphs (8)(e) and (f) below and to provisions relating to medical contraindication (paragraph (9)).

(c) All standard appeals, including, if not previously resolved in favor of the enrollee, a hearing before an impartial hearing officer, shall be resolved within ninety (90) days of receipt of the enrollee's request for an appeal. All expedited appeals involving time-sensitive care shall be resolved within thirty-one (31) days of receipt of the request for appeal. Calculation of the ninety (90) day or thirty-one (31) day deadline may be adjusted so that TennCare is not charged with any delays attributable to the enrollee. However, no delay may be attributed to an enrollee's request for a continuance of the hearing, if she received less than three (3) weeks' notice of the hearing, in the case of a standard appeal, or less than one (1) week's notice, in the case of an expedited appeal involving time-sensitive care. An enrollee may only be charged with the amount of delay occasioned by her acts or omissions, and any other delays shall be deemed to be the responsibility of TennCare.

(d) Failure to meet the ninety (90) day or thirty-one (31) day deadline, as applicable, shall result in automatic TennCare coverage of the services at issue pending a decision by the impartial hearing officer, subject to the provisions of subparagraphs (8)(e) and (f) below, and to provisions relating to medical contraindication (paragraph (9)). This conditional authorization will neither moot the pending appeal nor be evidence of the enrollee's satisfaction of the criteria for disposing of the case, but is simply a compliance mechanism for disposing of appeals within the required time frames. In the event that the appeal is ultimately decided against the enrollee, she shall not be liable for the cost of services provided past the deadline for resolution of the appeal.

(e) When, under the provisions of subparagraphs (8)(a), (b) or (d) above, a failure to comply with the time frames would require the immediate provision of a disputed service, TennCare may decline to provide the service pending a contrary order on appeal, based upon a determination that the disputed service is not a TennCare-covered service. A determination that a disputed service is not a TennCare-covered service may not be based upon a finding that the service is not medically necessary. Rather, it may only be made with regard to a service that:

1. Is subject to an exclusion that has been reviewed and approved by the federal Health Care Financing Administration and incorporated into a properly promulgated state regulation, or

2. Which, under Title XIX of the Social Security Act, is never federally reimbursable in any Medicaid program.

(f) When, under the provisions of subparagraphs (8)(a), (b) or (d) above, a failure to comply with the time frames would require the immediate provision of a disputed TennCare covered service but the enrollee lacks a prescription for such service, the enrollee shall be immediately afforded access, at the earliest time practicable, to a qualified provider to determine whether the service

should be prescribed. The provider will be informed that the service will be authorized if prescribed. Entitlement to the service will not be controlled by an MCC's utilization review process.

(g) Except upon a showing by an MCC of good cause requiring a longer period of time, within five (5) days of a decision in favor of an enrollee at any stage of the appeal process, the MCC must complete corrective action to implement the decision. Corrective action to implement the decision includes:

1. The enrollee's receipt of the services at issue, or acceptance and receipt of alternative services; or

2. Reimbursement for the enrollee's cost of services, if the enrollee has already received the services at her own cost; or

3. If the enrollee has already received the service, but has not paid the provider, ensuring that the enrollee is not billed for the service and ensuring that the enrollee's care is not jeopardized by non-payment.

(9) Medical Contraindication.

(a) Whenever the terms of this rule require the provision of TennCare benefits or services to an enrollee, such obligation shall be relieved upon the written certification of a provider who is familiar with the beneficiary's medical condition that the TennCare benefit or service in question is medically contraindicated. The provider must either be employed by the state or, if a licensed pharmacist determining contraindication with regard to a prescribed drug, must be making such determination consistent with pre-established standards and procedures approved by the state.

(b) If a TennCare service is determined to be medically contraindicated as set out above, written notice must be immediately provided to the enrollee, and the notice must be accompanied by the provider's certification that the service must be withheld in order to protect the enrollee's health or safety. A copy of the notice and provider certification must be forwarded to the Tennessee Justice Center.

(10) Special Provisions Relating to Children in State Custody. In addition to the rights and protections established by 42 C.F.R. Part 431, Subpart E and the terms of this rule, children in state custody shall also receive the following enhanced notice and appeal rights:

(a) The Tennessee Department of Children's Services (DCS) must provide notice of any delay in providing a TennCare service that is administered by DCS. Such delay is immediately appealable on that child's behalf and cannot be required to last a particular length of time before issuance of the notice or processing of an appeal.

(b) Whenever there is an adverse action affecting TennCare services (regardless of which contractor or government agency is administering such services), timely notices required by this rule must be sent to the individuals specified in the DCS implementation plan which was approved by the Court in Grier v. Wadley. In the case of services administered by MCCs other than DCS, the responsible MCC shall provide notice to DCS, which shall ensure that timely notice is provided to the required individuals. Delivery of notice triggering the right to appeal is not complete until notice is received by those individuals.

(c) An appeal from any individual specified in paragraph (10)(b) above must be accepted as an appeal on behalf of the child.

(Rule 1200-13-12-.11, continued)

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109, and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed March 18, 1994; effective June 1, 1994. Repeal and new rule filed January 25, 1997; effective April 9, 1997. Amendment filed February 1, 2001; effective April 17, 2001.*

1200-13-12-.12 OTHER APPEALS BY TENNCARE APPLICANTS AND ENROLLEES

(1) Non-Medicaid Enrollment, Disenrollment and Cost Sharing

(a) Non-Medicaid TennCare applicants and Enrollees will be given an opportunity to have an administrative hearing before the Commissioner regarding denial of their applications, cost sharing disputes, and disputes regarding disenrollment from TennCare. The following provisions shall govern this process:

1. If the Bureau has denied an application, a non-Medicaid applicant may appeal the denial. A request for appeal must be made within thirty (30) calendar days after the notice of the denial of the application is issued.

2. A TennCare Enrollee may request an appeal regarding a disenrollment determination, the amount an Enrollee is obligated to pay in cost sharing, or the amount an Enrollee is assessed in premium payments to TennCare, that the Enrollee believes is erroneous. A request for appeal must be submitted within thirty (30) calendar days after the written notice of the adverse action is issued.

(b) Notice requirements - Whenever the Bureau of TennCare denies an application for non-Medicaid enrollment in TennCare or determines an Enrollee will be disenrolled, it will send the non-Medicaid TennCare applicant written notice of the right to request an appeal to the Commissioner, as provided by these rules. The notice must contain:

1. An explanation of the reasons for the Bureau's actions, including a brief statement of the factual basis and the rule or contract provision relied upon by the Bureau;

2. An explanation of the circumstances under which the TennCare applicant can request an appeal; and

3. An explanation of the TennCare applicant's right to submit documents or other information in support of a request for appeal.

(2) Other Appeals

(a) Medicaid-certified Enrollees or Medicaid applicants have the right to appeal denials of Medicaid eligibility and termination of eligibility decisions to the Department of Human Services, in accordance with the provisions of Official Compilation Rules and Regulations of the State of Tennessee Chapter 1240-5-3 and the provisions and criteria set out in this chapter, as applicable.

(b) Enrollees applying for Seriously and Persistently Mentally Ill (SPMI) or Seriously Emotionally Disturbed (SED) determination shall apply for each determination to the Department of Mental Health and Mental Retardation unless otherwise directed by the Commissioner. SPMI and SED determinations shall be appealed in accordance with the provisions and criteria of federal and state law, as applicable.

Authority: *T.C.A. §§4-5-202, 71-5-105, 71-5-109 and Executive Order No. 23 of 1999.* ***Administrative History:*** *Original rule filed August 3, 1999; effective October 17, 1999. Amendment filed February 10, 2000; effective April 25, 2000. Amendment filed February 1, 2001; effective April 17, 2001.*